IDAHO BOARD OF HEALTH AND WELFARE
MINUTES
February 22, 2018

The Board of Health and Welfare convened at:
Pete T. Cenarrusa Building
450 W. State Street
Boise, Idaho 83720

BOARD MEMBERS PRESENT

Darrell Kerby, Chairman
Tom Stroschein, Vice-Chair
Russ Barron, Secretary
James Giuffré
Wendy Jaquet
Dr. Richard Roberge
Linda Hatzenbuehler
Senator Lee Heider

STAFF PRESENT

Lori Wolff, Deputy Director - FACS & Welfare Services
Lisa Hettinger, Deputy Director - Behavioral Health, Medicaid & Public Health
David N. Taylor, Deputy Director - Support Services and Licensing & Certification (L&C)
Tamara Prisock, Division Administrator - L&C
Cameron Gilliland, Deputy Division Administrator - Family & Community Services (FACS)
Debby Ransom, Bureau Chief – L&C
Nicole Wisenor, Program Supervisor – L&C
Nate Elkins, Program Supervisor – L&C
Elke Shaw-Tulloch, Division Administrator – Public Health
Dieuwke Spencer, Deputy Division Administrator – Public Health
Jeff Crouch, Western Hub Regional Director
Kathie Brack, Special Assistant to the Director
Niki Forbing-Orr, Public Information Manager
Chris Smith, Public Information Officer
Michael Farley, Division Administrator – Information & Technology (IT)
Mark Fortin, Project Manager- IT
Janet Sanabria, Technical Writer - IT
Lynn Overman, Liaison to the Board

OTHERS PRESENT

Nicole McKay, Lead Deputy Attorney General
Sara Stover, Analyst - Division of Financial Management
Jared Tatro, Legislative Services Office

Raine Saunders - Health Freedom Idaho
Miste Gardner-Karlfeldt - Health Freedom Idaho
Shalee Brindley - Health Freedom Idaho
Ashley Kates - Health Freedom Idaho
Sheriff Donahue, Canyon County
Captain Daren Ward - Canyon County Sheriff's Office
Andrew Kiehl - Canyon County Sheriff's Office
Graciela Rodriguez

CALL TO ORDER

Following proper notice in accordance with Idaho Code, Section 67-2343, and pursuant to call by the Chairman, the meeting of the Idaho Board of Health and Welfare was called to order by Darrell Kerby, Chairman of the Board, at 8:10 a.m. Thursday, February 22, 2018, at the Pete T. Cenarrusa Bldg., 450 W. State Street, Boise, Idaho.

ROLL CALL

Director Barron, Secretary, called the roll. Roll call showed **seven (7)** members present. With **five (5)** voting members present, Chairman Kerby declared a quorum. Absent and excused was Representative Fred Wood.
Dr. Richard Roberge arrived at 8:55 a.m., due to inclement weather and driving conditions.

PUBLIC COMMENT PERIOD

Chairman Kerby opened the floor for public comment. Several members of Health Freedom Idaho spoke about their concerns regarding vaccine safety. Miste Gardner-Karlfeldt read a letter that was provided to the US Department of Health and Human Services (HHS). Other members spoke about general vaccine safety, desired testing relating to autism and other possible adverse effects. Raine Saunders read a statement indicating that the HHS vaccine program should be changed to inform parents about vaccine safety in order to identify and reduce harms. A packet of handouts was provided. **(See Attachment 1)**. Health Freedom Idaho representatives stated they came to ask the Board to acknowledge that state government has an obligation to inquire about safety testing of vaccines and that the Department of Health and Welfare should comply with the investigation. Chairman Kerby thanked the members of Health Freedom Idaho for their presentation.

Sheriff Donahue expressed his support for the secure treatment facility for people with intellectual disabilities and the work of the Department of Health and Welfare (DHW). Canyon County jails are not equipped to handle individuals with intellectual disabilities. Those who are arrested because of crimes committed against others cannot remain in jail and receive the services they need. The DHW's behavioral health expertise is needed as SWITC provides the appropriate level of care and safety.

RESUME AND INTRODUCTION OF NEW BOARD MEMBER, LINDA HATZENBUEHLER

(See Attachment 2). Dr. Hatzenbuehler worked for the Department of Health and Welfare (DHW) in the Mental Health Division while completing her PhD in Psychology. Later, she worked for and then became Dean of the Division of Health Sciences at Idaho State University. Her work focus has been in forensics, completing evaluations for individuals with mental illness who are being held in custody.
Director Barron endorsed her appointment to the Board by Governor Otter. Her background and experience with behavioral health issues will be a great asset to the Board as well as her understanding of the Department's many programs and services. Chairman Kerby and members welcomed Dr. Hatzenbuehler to the Board.

ADOPTION OF MINUTES FROM BOARD MEETING ON NOVEMBER 16, 2017

Motion: Jim Giuffré moved that the minutes of the November 16, 2017, Board meeting be adopted as prepared.

Second: Tom Stroschein

Roll Call Vote:

Ayes: **Giuffré, Jaquet, Kerby, Stroschein, Hatzenbuehler**

Nays: **None**

Motion Carried

(See Attachment 3)

COMMENTS FROM BOARD MEMBERS

Jim Giuffré thanked presenters from Health Freedom Idaho. He stated all information reviewed by the Board and the DHW should be evidence based. Mr. Giuffré also reminded them of the exemption process currently in place for those who choose not to vaccinate children.

OVERVIEW: SECURE TREATMENT FACILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES

Cameron Gilliland, Deputy Division Administrator, (FACS), showed pictures of the new secure facility for those with intellectual disabilities. **(See Attachment 4).** This facility is located at the Southwest Idaho Treatment Center (SWITC) campus and has the capacity to house four (4) clients. This facility is required by law **(See Attachment 5)** for Developmentally Disabled (DD) individuals who are a safety risk to themselves or others. A secure facility is defined as one with locking doors, limited personal possessions that could potentially be used as weapons, higher staff to client ratios, alarms and security cameras. Clients must be assigned to the facility by court order and are subject to periodic reviews by the court. Complete access to records and the

facility are made to other agencies, including the DD Council, the American Civil Liberties Union, Idaho State Independent Living Council, and the Canyon County Sheriff's Department. Currently, no individuals have been assigned to the facility. An invitation was extended to Board members to tour the facility.

LICENSING AND CERTIFICATION, SECURE TREATMENT FACILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES: DOCKET NO. 16-0315-1801:

Presenter: Tamara Prisock

Tamara Prisock, Administrator of Licensing and Certification, presented the "Secure Treatment Facility for People with Intellectual Disabilities", rule docket for the Board's approval. **(See Attachment 6).**

This is the first facility of its kind in Idaho, and many resources were examined to create an appropriate model. A Human Rights Committee will oversee the facility. It should be noted the law provides for the type of facility required to obtain licensing to be operational and cannot simply have policies and procedures to operate the facility.

Ms. Prisock provided the verbal and written comments from the public during the negotiated rule making process, as well as a transcribed testimony from Sheriff Donahue of Canyon County, regarding this rule docket. **(See Attachments 7 & 8).**

Two public concerns arose that remain unresolved: 1.) The need for a secure facility. 2.) Objectivity by the DHW to oversee the facility because the L&C division is part of the DHW. To address this concern, Mr. Giuffré suggested that perhaps an outside licensing agency could be used for this facility, rather than the L&C division of the DHW. Tamara pointed out this would require a change to current law by the Legislature.

Chairman Kerby stated testimonies would not be received at this meeting, however - because of his late arrival, the expressions of Sheriff Donahue were allowed as part of the public comment period, noted in the section above.

Motion: Jim Giuffré moved that the Idaho Board of Health and Welfare adopt the "Temporary" rules for "Secure Treatment Facility for People with Intellectual Disabilities", presented under Docket No. 16-0315-1801, effective February 22, 2018.

Second: Tom Stroschein

Vote: Ayes: **Giuffré, Jaquet, Kerby, Stroschein, Hatzenbuehler, Roberge**

Nays: **None**

Motion Carried

MEDICAID/ BEHAVIORAL HEALTH/ PUBLIC HEALTH/ HEALTH POLICY INNOVATION UPDATE

Lisa Hettinger, Deputy Director reviewed Medicaid bills currently submitted to the Legislature. One deals with quality programs for skilled nursing facilities. Another bill addresses proposed federal waivers to provide healthcare for the uninsured population. There is also a bill to restore dental benefits to adults who lost this benefit due to reduced funding during the economic downturn. These benefits have been restored to the adult DD population. The data presented by the bill sponsor shows that poor oral health leads to other health issues. The bill sponsor linked the prevention of these conditions to a potential cost savings to Medicaid with restoration of this preventive benefit. Medicaid's data about these conditions and actual expenditures does not support the bill sponsor's savings estimates so a trailer bill will be required to find the benefit change if the bill passes.

The Behavioral Health division is working on a bill for minor changes in the members of the Behavioral Health Boards. It intends to codify the work with stakeholders to secure placement of appropriate members on the Boards.
Another bill changes physician classifications within the personnel system.
A bill regarding imposing a fee to help fund the tobacco monitoring program (selling tobacco to minors) failed. Previously, funds for this program came from the Millennium Fund. There are not enough violators to fund the program with these fees.
Funding for crisis centers appears to be moving through the Legislature.
Additionally, funding through a 30-year bond has been requested to replace the 80-year-old Syringa facility in Blackfoot. A handout of resident profiles and needs that require building updates was provided. **(See Attachment 9).** The Permanent Building Fund has asked the DHW to seek a bond through the Idaho Building Authority for the project that is likely to cost more than $30 million.

Public Health offered a one-page document listing Time Sensitive Emergency (TSE) facilities and the levels of designation and fees associated with them. **(See Attachment 10).**

A Public Health document was also provided **(See Attachment 11)** regarding Advanced Care Planning (ACP). The intent of ACP documents is to provide information about a patient's end-of-life wishes during an end-of-life situation. The goal is to create a computerized central registry where these documents may be readily accessed by medical providers across the state. This will require public and private sector stakeholder meetings to create universal procedures and update technology. Currently, a database exists at the Secretary of State's office, but accessibility is problematic due to outdated technology. Within the Treasure Valley, St. Luke's and St. Al's have been working on ideas to integrate a program within hospital systems. Proposals by the Health Quality Planning Commission (HQPC) and financial projections are provided in the document.

The State Healthcare Innovation Plan (SHIP) is in its fourth (final) year of its federal grant. Medicaid is benefitting from the work of the SHIP as they are now able to move to the Patient Centered Medical Home (PCMH) model of care for many more participants. The Telehealth Council is developing a strategic plan for Idaho. **Wendy Jaquet recommended a one-page document of explanation regarding what we have received for the federal funds spent on the SHIP be provided to the Legislature.**

As a follow-up to a discussion during the Board meeting held 11/16/17, Ms. Jaquet also inquired about the possibility of submitting legislation allowing coroners access to records evidencing opioid abuse and overdoses.

WELFARE/ FAMILY AND COMMUNITY SERVICES UPDATE

Lori Wolff, Deputy Director of Welfare and Family and Community Services (FACS), reported that the Idaho Health Care Plan (IHCP) Dual Waiver House Bill 464 (HB464), has moved from the Health and Welfare Committee to the House Floor. Director Barron stated a challenge for the DHW has been to educate the public and legislators about the waivers. The federal requirements for the waivers have been met, but the Department needs the Legislature's authority to submit the waivers to the Centers for Medicare and Medicaid. The Governor's office has been very supportive of HB464.

The FACS program is also waiting for the Legislature to pass a bill that would create an Oversight Board for Child Protection and Foster Care.

Key budget requests are for the technology update to the Child Welfare and Child Support Programs. The OPE report on Child Protection sights the need for updated system functionality. Also, federal funding for employment training services for Welfare recipients has been requested.

A question was raised as to whether the WIC Program has seen similar declines in participation as the SNAP program and the Division of Health confirmed that participation in this program has declined as the economy has improved.

BOARD ACCESS TO DHW INFONET/HEADLINE NEWS

Michael Farley, Division Administrator for the Information and Technology Division, introduced Mark Fortin, Project Manager. Mark was assisted by Janet Sanabria, Technical Writer. They provided handouts for each Board member with instructions for accessing the Department's InfoNet. **(See Attachment 12).** Individual user names and temporary passwords were also given to members. This will allow members access to Headline News as well as links to articles pertaining to the DHW.

DIVISION OF SUPPORT SERVICES UPDATE

Dave Taylor, Deputy Director of Support Services, provided members with a list of all Rules for the 2018 Legislative Session. **(See Attachment 13).** At the department's request, Rule 0308-1701 Temporary Assistance for Families in Idaho (TAFI) was rejected by the Health and Welfare germane committees. Modifications to the rule will be incorporated for submission during next year's legislative session.

A second handout **(See Attachment 14)** provided a status update about department legislation proposed during the current legislative session.

(Attachment 15) A summary of the department's second quarter financial review was shared and discussed with the Board.

DIRECTOR'S UPDATE

Director Barron thanked former Board members, Stephen Weeg and Janet Penfold for many years of service to the Board and welcomed Linda Hatzenbuehler as the newest member. Because of her appointment, an orientation binder was developed, and copies were provided for all members to keep and review. Appointment of a member from Region 7 is pending.

The dual waiver legislation has been a major initiative for the Department this year.

Four crisis centers are now operating, with three additional centers to be opened this year with approved funding from the Legislature.

Because the economy has improved, Director Barron is often asked why the DHW budget continues to grow. It is important to remember that not all the DHW does is reflected in the budget. For example, the actual dollar value of food stamp benefits is not reflected in the Department's budget because it is 100% federal funds. The total amount of food stamp benefits has dropped as program participation has declined. In January 2012, $32 million per month in federal food stamp benefits was distributed to program participants, and today that amount is about $17 million per month. This reduction is not reflected in the department's budget because these funds don't pass through the department. Regarding the budget increase, the main reason is the increase costs in Medicaid. The number of people enrolled in Medicaid has risen, and there are non-discretionary costs (mandatory cost) increases in Medicaid. Other than that, the single largest budget line item is the Idaho Health Care Plan recommendation.

The Department continues to work on suggestions from the Office of Performance Evaluation (OPE) reports regarding Child Welfare and Licensing & Certification.

Dr. Hatzenbuehler has served as chair on the Governor's Council on Suicide Prevention. The charge of the Council has been to develop a plan with various stakeholders to lower the suicide rate in Idaho. Hotline and Crisis Centers are the most important currently available intervention tools for suicide prevention, because results of the work they do is immediate. Initially, 60% of

funding for the hotline was provided by the Department's Suicide Prevention Program. Education in the schools is identified as second in prevention importance. The statistics for suicides for school aged children are higher in Idaho than the national average. Crisis centers are currently operated for adults only - there are no centers for youth. The Health Quality Planning Commission (HQPC) has encouraged the Council to increase collaboration over multiple agencies to improve suicide prevention.

ADJOURNMENT

The next meeting of the Idaho Board of Health and Welfare is scheduled to be held May 17, 2018. There being no further business to come before the Board, Chairman Kerby adjourned the meeting at 12:07 p.m.

Respectfully signed and submitted by:

Darrell Kerby, Chairman

Russell S. Barron, Secretary

Lynn Overman, Liaison to the Board

ATTACHMENT 1

HEALTH FREEDOM IDAHO

Your life. Your health. Your Way.

Health Freedom Foundation, Inc., a 501c4 non-profit corporation

Dear Sirs,

This is to inform the State of Idaho that the undersigned, including Health Freedom Idaho, have provided notice per 42 U.S.C. § 300aa-31(b) to the US Department of Health and Human Services. This notice requests confirmation that certain obligations regarding vaccine safety required under the 1986 National Childhood Vaccine Injury Act have been fulfilled or will forthwith be fulfilled: Deficiencies in the Pre-Licensure Safety Review of Pediatric Vaccines, Post-Licensure Surveillance of Vaccine Adverse Events, Identifying What Injuries Are Caused by Vaccines, Identifying Which Children are Susceptible to Vaccine Injury, Removing Claim "Vaccines Do Not Cause Autism" from the CDC Website, Refusal to Conduct Vaccinated Versus Unvaccinated Study, and Reducing Conflicts of Interest at HHS.

http://www.icandecide.com/white-papers/ICAN-HHS-Notice.pdf

Further Health Freedom Idaho formally submits to the State of Idaho, "Families are Under No Obligation to Put Their Children at Risk by Participating in the Corrupt Current US National Immunization Program," Ginger Taylor, Narrative Inquiry in Bioethics, Volume 6, Number 3, Winter 2016, pp. 181-185, (Article), Published by Johns Hopkins University Press, DOI: https://doi.org/10.1353/nib.2016.0068. This article and its supporting documents outline further corruption and deficits in the US National Immunization Program, and the Idaho Immunization Program.

http://muse.jhu.edu/pdfplus/journals/narrative_inquiry_in_bioethics/v006/6.3.taylor.pdf

In light of these issuances, Health Freedom Idaho believes that it is incumbent on the State of Idaho to review the information contained herein, the Idaho Immunization Program, the safety of vaccines currently being administered in the State of Idaho, the appropriate use of these vaccines, and the education of Idaho medical providers in reference to these products and their known risks.

Sincerely,

Miste Karlfeldt
Executive Director
Health Freedom Idaho
Miste.Karlfeldt@healthfreedomIdaho.org

ICAN
Informed Consent Action Network

VIA FEDEX

October 12, 2017

U.S. Department of Health & Human Services
HHS Office of the Secretary
Eric D. Hargan
Acting Secretary of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: *HHS Vaccine Safety Responsibilities and Notice Pursuant to 42 U.S.C. § 300aa-31*

Dear Secretary Hargan:

Informed Consent Action Network hereby provides notice per 42 U.S.C. § 300aa-31(b).

Americans, including the over 55 organizations listed below, whose members exceed 5 million Americans, are concerned about vaccine safety. The National Childhood Vaccine Injury Act of 1986 (the **1986 Act**) made nearly every aspect of vaccine safety the exclusive responsibility of the Department of Health & Human Services (**HHS**). As the Secretary of HHS (the **Secretary**), this means you shoulder virtually all responsibility for assuring the safety of vaccines administered to America's 78 million children.

This notice respectfully requests confirmation that certain obligations regarding vaccine safety required under the 1986 Act have been fulfilled or will forthwith be fulfilled. These specific requests are numbered sequentially in this notice. We would welcome the opportunity to meet and discuss reasonable means for complying with these requests. If that is not possible, the 1986 Act authorizes "a civil action ... against the Secretary where there is alleged a failure of the Secretary to perform any act or duty" under the 1986 Act.

I. Background

The 1986 Act granted economic immunity to pharmaceutical companies for injuries caused by their vaccines. (42 U.S.C. § 300aa-11.) The 1986 Act thereby eliminated the market force which drives safety for all other products – actual and potential product liability. Recognizing the unprecedented elimination of this market force, the 1986 Act makes HHS directly responsible for virtually every aspect of vaccine safety. (42 U.S.C. §§ 300aa-2, 300aa-27.)

When the CDC recommends a pediatric vaccine for universal use, it creates for that vaccine's maker a liability free market of 78 million children typically required by law to receive the vaccine. The number of required vaccines has grown rapidly since 1986. In 1983, the CDC recommended that babies under one receive two vaccines: DTP and Polio.[1] As of 2017, the CDC recommends that babies under one receive multiple doses of ten vaccines: DTaP, Polio, Hep B, Rotavirus, Hib, Pneumococcal, Influenza, MMR, Varicella, and Hep A.[2] In total, the current CDC childhood vaccine schedule includes 56 injections of 73 doses of 30 different vaccines.

II. Deficiencies in the Pre-Licensure Safety Review of Pediatric Vaccines

All drugs licensed by the FDA undergo long-term double-blind pre-licensure clinical trials during which the rate of adverse reactions in the group receiving the drug under review is compared to the rate of adverse reactions in a group receiving an inert placebo, such as a sugar pill or saline injection. For example: Enbrel's pre-licensure trials followed subjects up to 80 months and controls received a saline injection.[3] Lipitor's pre-licensure trials lasted a median of 4.8 years and controls received a sugar pill.[4] Botox's pre-licensure trials lasted a median of 51 weeks and controls received a saline injection.[5] And even with these long-term studies, drugs are still often recalled.

In contrast, vaccines are *not* required to undergo long-term double-blind inert-placebo controlled trials to assess safety. In fact, not a single one of the clinical trials for vaccines given to babies and toddlers had a control group receiving an inert placebo. Further, most pediatric vaccines currently on the market have been approved based on studies with inadequate follow-up periods of only a few days or weeks.

For example, of the two Hepatitis B vaccines licensed by the FDA for injection into one-day-old babies, Merck's was licensed after trials that solicited adverse reactions for *only five days* after vaccination and GlaxoSmithKline's was licensed after trials that solicited adverse reactions for *only four days* after vaccination.[6] Similarly, the HiB vaccines sold by these same companies were licensed based on trials which solicited adverse reactions for three and four days, respectively, after vaccination.[7] The only stand-alone polio vaccine was licensed after a mere 48-hour follow-up period.[8]

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[1] https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

[2] https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

[3] https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/103795s5503lbl.pdf

[4] https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020702s056lbl.pdf

[5] https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/103000s5302lbl.pdf

[6] https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM111111.pdf; https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM224503.pdf

[7] https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM253952.pdf; https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM179530.pdf

[8] https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM133479.pdf

Moreover, these trials either had no control group or a control group which received other vaccines as a "placebo."[9] This means each new vaccine need only be roughly as safe as one (or in some cases numerous) previously licensed vaccines. Such flawed and unscientific study designs cannot establish the actual safety profile of any vaccine. The real adverse event rate for a vaccine can only be determined by comparing subjects receiving the vaccine with those receiving an inert placebo. Yet, this basic study design, required for every drug, is not required before or after licensing a vaccine.

The 1986 Act expressly requires that you, as the Secretary, "shall make or assure improvements in ... the licensing ... and research on vaccines, in order to reduce the risks of adverse reactions to vaccines." (42 U.S.C. § 300aa-27(a)(2).) Given this statutory obligation:

(1) Please explain how HHS justifies licensing any pediatric vaccine without first conducting a long-term clinical trial in which the rate of adverse reactions is compared between the subject group and a control group receiving an inert placebo?

(2) Please list and provide the safety data relied upon when recommending babies receive the Hepatitis B vaccine on the first day of life?

III. Post-Licensure Surveillance of Vaccine Adverse Events

The lack of pre-licensure safety data leaves the assessment of vaccine safety to the post-licensing period when they are being administered to children in the "real world." To capture vaccine adverse events in the real world, the 1986 Act established the Vaccine Adverse Events Reporting System (**VAERS**) operated by HHS. (42 U.S.C. § 300aa-25.)

In 2016, VAERS received 59,117 reports of adverse vaccine events, including 432 deaths, 1,091 permanent disabilities, 4,132 hospitalizations, and 10,284 emergency room visits.[10]

However, only a tiny fraction of adverse vaccine events are reported to VAERS. An HHS-funded study by Harvard Medical School tracked reporting to VAERS over a three-year period at Harvard Pilgrim Health Care involving 715,000 patients and found that "fewer than 1% of vaccine adverse events are reported."[11] A U.S. House Report similarly stated: "Former FDA Commissioner David A. Kessler has estimated that VAERS reports currently represent only a fraction of the serious adverse events."[12]

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[9] Ibid.

[10] https://wonder.cdc.gov/vaers.html

[11] https://healthit.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

[12] https://www.congress.gov/106/crpt/hrpt877/CRPT-106hrpt877.pdf

Assuming VAERS captures a full 1 percent of adverse events – which is more than is estimated – the VAERS data above from 2016 may reflect that in that year alone there were 5,911,700 adverse vaccine events, including 43,200 deaths, 109,100 permanent disabilities, 413,200 hospitalizations, and 1,028,400 emergency room visits.

Of course, these figures are merely estimates. It would be far better if adverse events reports were automatically created and submitted to VAERS to avoid the issue of underreporting. Automated reporting would provide invaluable information that could clarify which vaccines might cause which harms and to whom, potentially avoiding these injuries and deaths.

The idea of automating adverse reaction reporting to VAERS is not new or even difficult to achieve.[13] An agency within HHS, the Agency for Healthcare Research and Quality, sought to do exactly that in 2007 when it provided an approximately $1 million grant to automate VAERS reporting at Harvard Pilgrim Health Care.[14] The result was the successful automation of adverse event reports at Harvard Pilgrim:

> *Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions … were identified.*[15]

These results should have been concerning to HHS since they show that over only a three-year period, there were 35,570 reportable reactions in just 376,452 vaccine recipients.

After automating adverse events reports at Harvard Pilgrim, the developers of this system asked the CDC to take the final step of linking VAERS with the Harvard Pilgrim system so that these reports could be automatically transmitted into VAERS. Instead, the CDC refused to cooperate. As the Harvard grant recipients explained:

> *Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation.*[16]

After three years and spending $1 million of taxpayers' money, the CDC refused to even communicate with the HHS' Harvard Medical School grant recipients. Given HHS's statutory mandate to assure safer vaccines, it should have rushed forward with automating VAERS reporting -- not ignored the requests by the HHS's Harvard grant recipients.

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[13] https://healthit.ahrq.gov/ahrq-funded-projects/electronic-support-public-healthy-vaccines-adverse-event-reporting-system

[14] https://healthit.ahrq.gov/sites/default/files/docs/publication/r18hs017035-lazarus-final-report-2011.pdf

[15] Ibid.

[16] Ibid.

While HHS strongly supports automating public health surveillance systems, when it comes to vaccine safety, the CDC has only supported projects that would limit VAERS to passive surveillance.[17] Automation would improve safety and address many of the long-standing issues and limitations raised by CDC regarding VAERS.[18] Capturing "fewer than 1% of vaccine adverse events" thirty years after the passage of the 1986 Act is unacceptable -- and potentially deadly.

The 1986 Act expressly provides that you, as the Secretary, "shall make or assure improvements in … adverse reaction reporting … in order to reduce the risks of adverse reactions to vaccines." (42 U.S.C. § 300aa-27(a)(2).) Given this statutory obligation:

(3) Please explain why HHS failed to cooperate with Harvard to automate VAERS reporting? And detail any steps that HHS has taken since toward automating VAERS reporting?

(4) Please explain any specific steps taken by HHS to improve adverse reaction reporting to VAERS?

IV. Identifying What Injuries Are Caused by Vaccines

The first step in assuring safer vaccines is to identify what harms they cause. This would normally be accomplished pre-licensure by long-term, inert-placebo controlled trials – but these are never performed for vaccines. As for post-licensure monitoring, HHS has refused to improve VAERS as discussed above. Hence, assessing which vaccines cause which injuries is mainly left to post-licensure studies. HHS, unfortunately, has neglected to perform these studies.

In 1991, the Institute of Medicine (**IOM**) examined 22 commonly reported serious injuries following the DTP vaccine.[19] The IOM concluded the scientific literature supported a causal relationship between the DTP vaccine and 6 of these injuries: acute encephalopathy, chronic arthritis, acute arthritis, shock and unusual shock-like state, anaphylaxis, and protracted inconsolable crying.[20] The IOM, however, found the scientific literature was insufficient to conclude whether or not the DTP vaccine can cause 12 other serious injuries:

> *Aseptic meningitis; Chronic neurologic damage; Learning disabilities and attention-deficit disorder; Hemolytic anemia; Juvenile diabetes; Guillain-Barre syndrome; Erythema multiforme; Autism; Peripheral mononeuropathy; Radiculoneuritis and other neuropathies; Thrombocytopenia; Thrombocytopenic purpura*[21]

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[17] http://www.ajpmonline.org/article/S0749-3797(12)00219-8/pdf; https://www.ncbi.nlm.nih.gov/pubmed/26209838; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4632204/

[18] Ibid.

[19] https://www.nap.edu/read/1815/chapter/2#7

[20] Ibid.

[21] Ibid.

The IOM lamented that it "encountered many gaps and limitations in knowledge bearing directly and indirectly on the safety of vaccines" and on the poor design of the few existing studies.[22] It therefore cautioned that: "If research capacity and accomplishment in this field are not improved, future reviews of vaccine safety will be similarly handicapped."[23]

In 1994, the IOM issued another report which examined the scientific literature for evidence that could either prove or disprove a causal link between 54 commonly reported serious injuries and vaccination for diphtheria, tetanus, measles, mumps, polio, hepatitis B, and Hib.[24] The IOM located sufficient science to support a causal connection between these vaccines and 12 injuries, including death, anaphylaxis, thrombocytopenia, and Guillain-Barre syndrome.[25] The IOM, however, found the scientific literature was insufficient to conclude whether or not these vaccines caused 38 other commonly reported serious injuries, including:

> *Demyelinating diseases of the central nervous system, Sterility, Arthritis, Neuropathy, Residual seizure disorder, Transverse myelitis, Sensorineural deafness, Optic neuritis, Aseptic meningitis, Insulin-dependent diabetes mellitus, SIDS*[26]

As in 1991, this IOM Report again stated, "The lack of adequate data regarding many of the adverse events under study was of major concern to the committee. Presentations at public meetings indicated that many parents and physicians share this concern."[27]

In 2011, more than fifteen years after the IOM Reports in 1991 and 1994, HHS paid the IOM to conduct another assessment regarding vaccine safety.[28] This third IOM Report reviewed the available science with regard to the 158 most common vaccine injuries claimed to have occurred from vaccination for varicella, hepatitis B, tetanus, measles, mumps, and rubella.[29] The IOM located science which "convincingly supports a causal relationship" with 14 of these injuries, including pneumonia, meningitis, hepatitis, MIBE, febrile seizures, and anaphylaxis.[30] The review found sufficient evidence to support "acceptance of a causal relationship" with 4 additional serious injuries.[31]

The IOM, however, found the scientific literature was insufficient to conclude whether or not those vaccines caused 135 other serious injuries commonly reported after their administration, including:

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[22] https://www.nap.edu/read/1815/chapter/2#3
[23] https://www.nap.edu/read/1815/chapter/2
[24] https://www.nap.edu/read/2138/chapter/2#12
[25] https://www.nap.edu/read/2138/chapter/2#12
[26] Ibid.
[27] https://www.nap.edu/read/2138/chapter/12
[28] https://www.nap.edu/read/13164/chapter/2#2
[29] Ibid.
[30] https://www.nap.edu/read/13164/chapter/2#3
[31] Ibid.

Encephalitis, Encephalopathy, Infantile Spasms, Afebrile Seizures, Seizures, Cerebellar Ataxia, Acute Disseminated Encephalomyelitis, Transverse Myelitis, Optic Neuritis, Neuromyelitis Optica, Multiple Sclerosis, Guillain-Barre Syndrome, Chronic Inflammatory Demyelinating Polyneuropathy, Brachial Neuritis, Amyotrophic Lateral Sclerosis, Small Fiber Neuropathy, Chronic Urticaria, Erythema Nodosum, Systemic Lupus Erythematosus, Polyarteritis Nodosa, Psoriatic Arthritis, Reactive Arthritis, Rheumatoid Arthritis, Juvenile Idiopathic Arthritis, Arthralgia, Autoimmune Hepatitis, Stroke, Chronic Headache, Fibromyalgia, Sudden Infant Death Syndrome, Hearing Loss, Thrombocytopenia, Immune Thrombocytopenic Purpura[32]

Thus, out of the 158 most common serious injuries reported to have been caused by the vaccines under review, the evidence supported a causal relationship for 18 of them, rejected a causal relationship for 5 of them, but for the remaining 135 vaccine-injury pairs, over 86 percent of those reviewed, the IOM found that the science simply had not been performed.[33]

The 1986 Act expressly provides that you, as the Secretary, "shall promote the development of childhood vaccines that result in fewer and less adverse reactions" and "shall make or assure improvements in ... the ... labeling, warning, ... and research on vaccines, in order to reduce the risks of adverse reactions to vaccines." (42 U.S.C. § 300aa-27(a)(2).) The first step in reducing adverse reactions is identifying what adverse reactions are caused by vaccine. Given this statutory obligation:

(5) For each of the 38 vaccine-injury pairs reviewed in the 1994 IOM Report which the IOM found lacked studies to determine causation, please identify the studies undertaken by the HHS to determine whether each injury is caused by vaccination?

(6) For each of the 135 vaccine-injury pairs reviewed in the 2011 IOM Report which the IOM found lacked studies to determine causation, please identify the studies undertaken by the HHS to determine whether each injury is caused by vaccination?

Further to your duties to identify what injuries are caused by vaccines, the 1986 Act also expressly requires you to "make or assure improvements in ... the ... recall of reactogenic lots or batches, of vaccines ... in order to reduce the risks of adverse reactions to vaccines" and thus each "health care provider who administers a vaccine ... shall record ... in such person's permanent

[32] Ibid.

[33] Ibid.

medical record … the vaccine manufacturer and lot number." (42 U.S.C. §§ 300aa-25(a), 300aa-27(a)(2).) Since health care providers often fail to record this information:

(7) Please explain what HHS has done to assure that health care providers record the manufacturer and lot number for each vaccine they administer?

V. Identifying Which Children are Susceptible to Vaccine Injury

The IOM has consistently acknowledged there is individual susceptibility to serious vaccine injuries. The IOM has also acknowledged that research on such susceptibility must be done on an individual basis, considering a child's personal genome, behaviors, microbiome, intercurrent illness, and present and past environmental exposure. HHS, unfortunately, has not conducted this research.

In 1994, the IOM, building on concerns raised in its 1991 report, stated: "The committee was able to identify little information pertaining to why some individuals react adversely to vaccines when most do not."[34] The IOM urged that "research should be encouraged to elucidate the factors that put certain people at risk."[35]

Yet, seventeen years later, in 2011, the IOM acknowledged this research had still not been done:

> *Both epidemiologic and mechanistic research suggest that most individuals who experience an adverse reaction to vaccines have a preexisting susceptibility. These predispositions can exist for a number of reasons—genetic variants (in human or microbiome DNA), environmental exposures, behaviors, intervening illness, or developmental stage, to name just a few—all of which can interact…*
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> *Some of these adverse reactions are specific to the particular vaccine, while others may not be. Some of these predispositions may be detectable prior to the administration of vaccine… much work remains to be done to elucidate and to develop strategies to document the immunologic mechanisms that lead to adverse effects in individual patients.* [36]

In 2013, HHS commissioned the IOM to review the safety of the entire vaccine schedule.[37] The IOM again explained that while "most children who experience an adverse reaction to immunization have preexisting susceptibility," the IOM:

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[34] https://www.nap.edu/read/2138/chapter/12#307. *See also* https://www.nap.edu/read/1815/chapter/9

[35] Ibid.

[36] https://www.nap.edu/read/13164/chapter/5#82

[37] https://www.nap.edu/read/13563/chapter/1

HHS had failed to even define the terminology for the study of susceptible subpopulations and hence IOM admonished HHS to "develop a framework that clarifies and standardizes definitions of ... populations that are potentially susceptible to adverse events."[39]

The IOM correctly points out in 2011 that given the "widespread use of vaccines" and "state mandates requiring vaccination of children ... it is essential that safety concerns receive assiduous attention."[40] This is the same call for diligent attention that the IOM made in 1991 and 1994. Unfortunately, all of these calls for action have gone unheeded. The critical scientific inquiry to identify individuals susceptible to serious vaccine injury has never been conducted.

The 1986 Act expressly provides that you, as the Secretary, "shall promote the development of childhood vaccines that result in fewer and less adverse reactions" and "shall make or assure improvements in ... the ... labeling, warning, ... and research on vaccines, in order to reduce the risks of adverse reactions to vaccines." (42 U.S.C. § 300aa-27(a)(2).) Given this statutory obligation:

> **(8) Please advise when HHS intends to begin conducting research to identify which children are susceptible to serious vaccine injury? If HHS believes it has commenced this research, please detail its activities regarding same?**

VI. Removing Claim "Vaccines Do Not Cause Autism" from the CDC Website

HHS, unfortunately, has treated vaccine safety as a public relations issue rather than a public health imperative. For example, the CDC claims on its website that "Vaccines Do Not Cause Autism" even though this broad claim is plainly not supported by the scientific literature.[41]

Indeed, as part of the IOM's 2011 review of vaccine safety, it was asked by HHS whether there is a causal relationship between autism and the DTaP vaccine administered to children at two, four, six, and fifteen months of age.[42] The IOM could not locate a single study supporting

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[39] https://www.nap.edu/read/13563/chapter/9#130
[39] Ibid.
[40] https://www.nap.edu/read/13164/chapter/3#28
[41] https://www.cdc.gov/vaccinesafety/concerns/autism.html
[42] https://www.nap.edu/read/13164/chapter/2#2

that DTaP does not cause autism.[43] The IOM therefore concluded: "The evidence is inadequate to accept or reject a causal relationship between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and autism."[44] The IOM's full explanation in its 2011 Report for this finding is attached as Appendix B. In fact, the only study the IOM could locate regarding whether DTaP causes autism, (Geier and Geier, 2004), concluded there *was* an association between DTaP and autism.[45] No research has been published since 2011 that could change the IOM's conclusion. Based on the foregoing, the CDC cannot validly make the blanket assertion that there is no causal relationship between vaccines and autism. The CDC nonetheless claims on its website that "Vaccines Do Not Cause Autism."

As with DTaP, there are also no published studies showing that autism is not caused by Hepatitis B, Rotavirus, Hib, Pneumococcal, Inactivated Poliovirus, Influenza, Varicella, or Hepatitis A vaccines – all of which HHS recommends babies receive, typically multiple times, by one year of age.[46]

Instead, HHS's claim that "Vaccines Do Not Cause Autism" relies almost entirely upon studies exclusively studying only one vaccine, MMR (which is administered no earlier than one year of age), or only one vaccine ingredient, thimerosal, with regard to autism.[47] Putting aside the controversy surrounding these studies, studies which focus on only one vaccine and one ingredient while ignoring the entire balance of the CDC's pediatric vaccine schedule cannot support the CDC's overarching declaration that "Vaccines Do Not Cause Autism."

As for the MMR vaccine, the CDC's own Senior Scientist, Dr. William Thompson[48], recently provided a statement through his attorney that the CDC "omitted statistically significant information" showing an association between the MMR vaccine and autism in the first and only MMR-autism study ever conducted by the CDC with American children.[49] Dr. Thompson, in a recorded phone call, stated the following regarding concealing this association: "Oh my God, I can't believe we did what we did. But we did. It's all there. It's all there. I have handwritten notes."[50] Dr. Thompson further stated on that call:

> *I have great shame now when I meet families with kids with autism because I have been part of the problem … the CDC is so paralyzed right now by anything related to autism. They're not doing what they should be doing because they're afraid to look for things that might be associated. So anyway*

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[43] https://www.nap.edu/read/13164/chapter/12#545

[44] Ibid.

[45] Ibid. Ironically, this study was disregarded "because it provided data from a passive surveillance system [VAERS] and lacked an unvaccinated comparison population," which would be true of any study using VAERS data.

[46] https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

[47] https://www.cdc.gov/vaccinesafety/concerns/autism.html

[48] Dr. Thompson has been a scientist at CDC for nearly two generations and a senior scientist on over a dozen CDC publications at the core of many of CDC's vaccine safety claims. https://www.ncbi.nlm.nih.gov/pubmed

[49] http://www.rewellpost.com/files/william-thompson-statement-27-august-2014-3.pdf

[50] https://soundcloud.com/lernoticias/cdc-whistle-blower-full-audio

there's still a lot of shame with that. … I am completely ashamed of what I did.[51]

Hence, as for the only vaccine, MMR, actually studied by the CDC with regard to autism, it appears the CDC may have concealed an association between that vaccine and autism.[52]

When the former Director of the National Institute of Health, Dr. Bernadine Healy, was asked about whether public health authorities are correct to claim that vaccines do not cause autism, she answered: "You *can't* say that."[53] When asked again, Dr. Healy explained: "The more you delve into it – if you look at the basic science – if you look at the research that's been done, in animals – if you also look at some of these individual cases – *and*, if you look at the evidence that there *is* no link - what I come away with is: *The question has not been answered.*"[54]

Former NIH Director Dr. Healy goes on to explain:

> *This is the time when we do have the opportunity to understand whether or not there are susceptible children, perhaps genetically, perhaps they have a metabolic issue, mitochondrial disorder, immunological issue, that makes them more susceptible to vaccines plural, or to one particular vaccine, or to a component of vaccine... I haven't seen major studies that focus on - three hundred kids, who got autistic symptoms within a period of a few weeks of a vaccine. I think that the public health officials have been too quick to dismiss the hypothesis as irrational, without sufficient studies of causation. …*
>
> *The reason why they didn't want to look for those susceptibility groups was because they're afraid if they found them—however big or small they were—that that would scare the public away. First of all, I think the public's smarter than that; the public values vaccines. But, more importantly, I don't think you should ever turn your back on any scientific hypothesis because you're afraid of what it might show!*[55]

The CDC has also failed to address the science supporting a link between vaccines and autism.[56] For example, the CDC has not addressed a study which found a 300% increased rate of autism among newborns receiving the hepatitis B vaccine at birth compared to those that did not.[57] Nor a recent and first ever vaccinated vs. unvaccinated pilot study which found vaccinated

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[51] Ibid.

[52] Studies of MMR and autism are also erroneous because of healthy user bias, which has been emphasized as a serious source of error in epidemiological vaccine safety studies by CDC scientists. https://doi.org/10.1093/oxfordjournals.aje.a116479

[53] http://www.cbsnews.com/news/the-open-question-on-vaccines-and-autism/

[54] Ibid.

[55] Ibid.

[56] https://www.cdc.gov/vaccinesafety/concerns/autism.html

[57] http://thisunim.org.il/images/documents/scientific_literature/Gallagher_Goodman_Hep_B_2010.pdf

children had a 420% increased rate of autism and that vaccinated preterm babies had an even higher rate of autism.[58] There is also a persuasive body of science supporting a clear connection between aluminum adjuvants in vaccines and autism which the CDC, despite numerous requests, has failed to directly or substantively address.[59] Letters from three aluminum adjuvant experts on this point are attached as Appendix C.

The critical need for HHS to properly engage in vaccine safety science regarding autism is made even more vital by the fact that vaccine makers are immune from liability for vaccine injury and vaccines are not safety-tested prior to licensure to assess whether they cause autism. Without proper long-term trials comparing those receiving the vaccine to an inert-placebo group, it is impossible to know prior to licensure whether these products cause autism. There are also no follow-up studies which compare vaccinated with unvaccinated individuals and hence no supportable basis to claim that vaccines do not cause any cases of autism. For the CDC to make this claim, it must demonstrate that a child receiving the entire vaccine schedule is at no greater risk of becoming autistic than a child that is unvaccinated. No such study has ever been done. The IOM Report referenced above has confirmed that the CDC cannot make this claim even for children receiving only the DTaP vaccine, let alone the entire vaccine schedule.

The 1986 Act expressly provides that you, as the Secretary, are to "develop and disseminate vaccine information materials for distribution by health care providers to the legal representatives of any child or to any other individual receiving a vaccine set forth in the Vaccine Injury Table." (42 U.S.C. § 300aa-26(a).) This section further provides that:

> The information in such materials shall be based on available data and information ... and shall include ... (1) a concise description of the benefits of the vaccine, (2) a concise description of the risks associated with the vaccine, (3) a statement of the availability of the National Vaccine Injury Compensation Program, and (4) such other relevant information as may be determined by the Secretary.

(42 U.S.C. § 300aa-26(c).) The VIS produced for every vaccine, including for DTaP, provides that other relevant information regarding the vaccine is available at the CDC website, www.cdc.gov.[60] The CDC website in turn claims that "Vaccines Do Not Cause Autism."[61] Since HHS has chosen to incorporate the CDC's website into the VIS as a resource, the information on that website regarding the relevant vaccine must be "based on available data and information." *Id.* But, based on available data and information, as highlighted by the IOM, HHS cannot validly claim that "Vaccines Do Not Cause Autism." Hence:

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[58] http://www.oatext.com/pdf/IIS-3-187.pdf; http://www.oatext.com/pdf/IIS-3-187.pdf

[59] http://vaccine-safety.s3.amazonaws.com/WhitePaper-AlumAdjuvantAutism.pdf

[60] https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

[61] https://www.cdc.gov/vaccinesafety/concerns/autism.html

(9) Please confirm that HHS shall forthwith remove the claim that "Vaccines Do Not Cause Autism" from the CDC website, or alternatively, please identify the specific studies on which HHS bases its blanket claim that no vaccines cause autism?

VII. Refusal to Conduct Vaccinated Versus Unvaccinated Study

The only scientifically valid way to answer a large portion of the questions raised regarding vaccine safety would be a long-term, properly powered and controlled study comparing the rate of all adverse events between vaccinated children and completely unvaccinated children. This is the same type of study required by HHS for every drug pre-licensure. HHS has nonetheless refused to conduct any such study, even retrospectively.

The need for this study is highlighted by the results of a few recent limited vaccinated vs. unvaccinated studies.

Dr. Peter Aaby is renowned for studying and promoting vaccines in Africa with over 300 published studies.[62] In 2017, he published a study finding children vaccinated with DTP were 10 times more likely to die in the first 6 months of life than the unvaccinated.[63] Dr. Aaby's study therefore concluded that: "All currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis."[64] More disturbing is that children vaccinated with DTP were dying from causes never associated with this vaccine, such as respiratory infections, diarrhea, and malaria.[65] This indicated that while DTP reduced the incidence of diphtheria, tetanus, and pertussis, it increased susceptibility to other infections.[66]

It is equally troubling that Dr. Abby's study was based on data that had been collecting dust for over 30 years[67] This begs the question: what other serious vaccine injuries are we missing because of neglect to conduct proper vaccine safety science.

A pilot study comparing 650 vaccinated and unvaccinated homeschooled children in the United States provides a glimpse of the potential scope of vaccine harm.[68] The study found that, compared to completely-unvaccinated children, fully-vaccinated children had an increased risk

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[62] https://www.ncbi.nlm.nih.gov/pubmed/?term=PETER_AABY%5BAuthor%5D+Full%5D

[63] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5360769/ Dr. Aaby's study was more reliable than other vaccine safety studies because the subjects were accurately matched. An increasingly recognized problem in vaccine safety studies is that subjects are typically not well-matched. People with pre-existing health problems are reluctant to receive a vaccine, and are therefore unwittingly used as controls. When this happens, the control group is sicker than the vaccine-exposed group at the outset of the study. Studies with this problem give wrong results, and make the vaccine look much safer than it really is. Dr. Aaby's study was one of the few specifically designed to avoid this error.

[64] Ibid.

[65] Ibid.

[66] Ibid.

[67] Ibid.

[68] http://www.cotext.com/pdf/JTS-3-186.pdf

of 390% for allergies, 420% for ADHD, 420% for autism, 290% for eczema, 520% for learning disabilities, and 370% for any neuro-developmental delay.[69] Fully-vaccinated pre-term infants had an increased risk of 1,450% for a neurodevelopmental disorder, which includes a learning disability, ADHD or autism, compared to completely unvaccinated preterm infants.[70]

Another recent study compared children receiving the flu shot with those receiving a saline injection in a prospective randomized double-blind study.[71] Both groups had the same rate of influenza but the group receiving the flu shot had a 440% increased rate of non-influenza infection.[72] Like the DTP study, the flu vaccine increased susceptibility to other infections.

A properly sized vaccinated versus unvaccinated study is necessary and possible. As stated by the IOM in 2013: "It is possible to make this comparison through analyses of patient information contained in large databases such as VSD."[73] Senior CDC Scientist, Dr. Thompson similarly stated this type of study can and "needs to be done" but that the CDC is "not doing what they should be doing because they're afraid to look for things that might be associated."[74] When vaccine makers are generating over $33 billion in vaccine revenue annually and the CDC is spending over $5 billion annually to promote and purchase vaccines, there is no justification for not performing this study.[75]

The 1986 Act expressly provides that you, as the Secretary, "shall promote the development of childhood vaccines that result in fewer and less adverse reactions" and "shall make or assure improvements in ... the ... labeling, warning, ... and research on vaccines, in order to reduce the risks of adverse reactions to vaccines." (42 U.S.C. § 300aa-27(a)(2).) Since comparing children receiving the vaccines recommended by the CDC with those that have not received any vaccines is the only scientifically valid way to assess the safety of the CDC's vaccine schedule:

(10) Please advise whether HHS intends to forthwith conduct adequately powered and controlled prospective as well as retrospective studies comparing total health outcomes of

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[69] Ibid.

[70] https://www.omicsonline.com/pdf/EIS-3-187.pdf

[71] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3884712/

[72] Ibid. *See also* http://vaccine-safety.s3.amazonaws.com/CDC_FOIA_ResponseUnpublishedStudy.pdf (The CDC in 2001 apparently conducted a narrow vaccinated versus unvaccinated study comparing children receiving the Hepatitis B vaccine during the first month of life versus those who did not. The results of this study were never released by the CDC, and an abstract of the study was only recently obtained under a FOIA request. Children vaccinated with Hepatitis B vaccine in the first month of life, compared to children receiving no vaccines in the first month of life, had an increased risk of 829% for ADHD, 762% for autism, 638% for ADD, 565% for tics, 498% for sleep disorders, and 206% for speech delays. Note that while the abstract discusses comparing thimerosal exposure, since the only vaccine recommended by one month of age was Hepatitis B, and since only thimerosal containing Hepatitis B vaccine was available at the time of this study, this study appears to have primarily compared children receiving Hepatitis B with children that did not receive this vaccine.)

[73] https://www.nap.edu/read/13563/chapter/2#13

[74] https://soundcloud.com/fomotion/cdc-whistle-blower-full-audio

[75] https://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf; https://www.beccaresearch.com/market-research/pharmaceuticals/vaccine-technologies-markets-report-phm014f.html

fully/partially vaccinated children with completely unvaccinated children?

VIII. Reducing Conflicts of Interest at HHS

The 1986 Act created a system in which vaccines are licensed, recommended, encouraged, subsidized, and defended by HHS. The 1986 Act's scheme thus places HHS in charge of two competing duties. On one hand, HHS is responsible for vaccine safety. On the other hand, HHS is required to promote vaccine uptake and defend against any claim they cause any harm.

Regrettably, it appears that HHS has chosen to focus almost entirely on its vaccine promotion and defense function to such a degree that it has essentially abandoned its vaccine safety function. To restore balance, HHS must take serious steps to create an "ethics firewall" between these competing functions. HHS also must take action with regard to its vaccine committee members and employees that have conflicts with vaccine makers.

HHS Licenses & Recommends Vaccines. With regard to the FDA's Vaccines and Related Biological Products Advisory Committee (**VRBPAC**), which effectively decides whether to license a vaccine, in 2000 the U.S. House Committee on Government Reform (the **Committee**) "determined that conflict of interest rules employed by the FDA and the CDC have been weak, enforcement has been lax, and committee members with substantial ties to pharmaceutical companies have been given waivers to participate in committee proceedings."[76] The Committee concluded of the VRBPAC: "The overwhelming majority of members, both voting members and consultants, have substantial ties to the pharmaceutical industry."[77]

With regard to the CDC's Advisory Committee on Immunization Practices (**ACIP**), which effectively decides whether to universally recommend a pediatric vaccine, the Committee found that ACIP members routinely fail to disclose conflicts with vaccine makers and when conflicts are disclosed "[t]he CDC grants blanket waivers to the ACIP members each year that allow them to deliberate on any subject, regardless of their conflicts."[78] The Committee drew focus on the vaccine most recently approved by the ACIP and found extensive and troubling conflicts of interest for most the ACIP members voting to recommend its universal use for children.[79] The Committee was further concerned that "ACIP liaison representatives have numerous ties to

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[76] http://vaccinesafetycommission.org/pdfs/Conflicts-Gov't-Reform.pdf (For instance, "3 out of 5 FDA advisory committee [VRBPAC] members who voted to approve the rotavirus vaccine in December 1997 [then the most recently approved vaccine by the VRBPAC] had significant financial ties to pharmaceutical companies that were developing different versions of the vaccine.")

[77] Ibid.

[78] Ibid.

[79] Ibid. (The Committee's findings were that: (1) The chairman served on Merck's Immunization Advisory Board; (2) another member, who shared the patent on a rotavirus vaccine, had a $350,000 grant from Merck to develop the vaccine, and was a consultant for Merck; (3) another member was under contract with the Merck Vaccine Division, a principal investigator for SmithKline and received funds from various vaccine makers; (4) another member received a salary and other payments from Merck; (5) another member participated in vaccine studies with Merck, Wyeth, and SmithKline; and (6) another member received grants from Merck and SmithKline.)

vaccine manufacturers" but act like voting members of ACIP.[80] The Committee further took issue with the extensive conflicts of interests of members of ACIP's working groups which convene behind closed doors and whose recommendations are typically rubber stamped by the ACIP.[81] The Committee concluded that ACIP reflected "a system where government officials make crucial decisions affecting American children without the advice and consent of the governed."[82]

Despite the concerns the Committee expressed in its 2000 report, not much changed. A December 2009 report by the HHS Office of Inspector General found that the "CDC had a systemic lack of oversight of the ethics program for SGEs [a.k.a. **committee members**]".[83] For example, "Most of the experts who served on advisory panels in 2007 to evaluate vaccines for flu and cervical cancer had potential conflicts that were never resolved."[84]

In fact, the Inspector General found that the "CDC certified [conflict disclosure forms] with at least one omission in 2007 for 97 percent ... of SGEs," "58 percent ... of SGEs had at least one potential conflict of interest that CDC did not identify," and when the CDC identified a conflict, it improperly granted broad waivers despite being castigated for this improper practice in 2000.[85] Even worse, "32 percent ... of SGEs ... had at least one potential conflict of interest that CDC identified but did not resolve" and 13 percent of SGEs were allowed to participate in committee meetings without even having a conflict disclosure form on file.[86]

As the system is set up, an ACIP vote to recommend a vaccine, grants a vaccine manufacturer a liability-free market of 78 million American children, who are legally compelled to receive the vaccine, and billions of taxpayer dollars guaranteeing payment. In such a system, an ACIP vote must be completely insulated from any influence by the vaccine manufacturer. Instead, the opposite appears to be the norm.

HHS Promotes Vaccines. Moreover, while the CDC states on its website -- not less than 130 times -- that "CDC does not accept commercial support," this is simply not true.[87] For example, the British Medical Journal reported in 2015 that: "Despite the agency's disclaimer, the CDC does receive millions of dollars in industry gifts and funding, both directly and indirectly, and several recent CDC actions and recommendations have raised questions about the science it cites, the clinical guidelines it promotes, and the money it is taking."[88] As another example, pharmaceutical companies and other private entities, through the "CDC Foundation," can create and fund programs at the CDC (over half a billion dollars' worth to-date), endow positions at the

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[80] Ibid.
[81] Ibid.
[82] Ibid.
[83] https://oig.hhs.gov/oei/reports/oei-04-07-00260.pdf
[84] http://www.nytimes.com/2009/12/13/health/policy/13cdc.html
[85] https://oig.hhs.gov/oei/reports/oei-04-07-00261.pdf (Splicing down this 58% of unidentified conflicts, 40% involved employment or grants, 13% involved equity ownership, and 5% involved consulting.)
[86] Ibid.
[87] https://search.cdc.gov/search?query=%22cdc+does+not+accept+commercial+support%22&utf8=%E2%9C%93&affiliate=cdc_main
[88] http://www.bmj.com/content/350/bmj.h2262

CDC, and even place individuals to work at the CDC, paid through "private funding." (42 U.S.C.A. § 280e-11(h)(1), (2).)

Worse, the promotion track for CDC management extends into vaccine makers. The most prominent example is former CDC Director Dr. Julie Gerberding, who headed the agency from 2002 through 2009. Dr. Gerberding oversaw several controversial studies regarding vaccines produced by Merck, which sought to silence those calling for an increase in the safety profile of those vaccines. When she left the CDC she was rewarded with the position of President of Merck Vaccines in 2010 with a reported $2.5 million annual salary and lucrative stock options.[89]

HHS Defends Vaccines. After HHS licenses, effectively mandates, and promotes a vaccine to 78 million American children with very limited safety data, this very same government agency is mandated to defend against any claim that the vaccine caused harm.

There is no other for-profit product where the very department responsible for regulating that product is statutorily required to promote its uptake and simultaneously defend against any claim it causes harm.

The Vaccine Injury Compensation Program (**VICP**) is effectively the only legal recourse in America to obtain compensation for a pediatric vaccine injury. (42 U.S.C. § 300aa-10 *et seq.*)[90] The injured must litigate against HHS and the DOJ in a quasi-judicial process filed under seal where the injured child effectively cannot obtain documents from or depose vaccine makers to prove how the vaccine caused injury. (§ 300aa-12.) DOJ and HHS have the government's vast resources, while the injured child must secure a private attorney. (§ 300aa-15.) Moreover, the injured child's damages are limited to $250,000 for death and pain and suffering. (*Id.*)

Worst of all, the injured child must almost always prove "causation" – the biological mechanism by which the vaccine injured the child.[91] Requiring an injured child to prove causation adds insult to injury because had HHS conducted the vaccine safety science it demands as proof in the VICP before licensing a vaccine, the child's injury may have been avoided altogether.

This truly is the epitome of injustice: requiring a child receiving a compulsory pharmaceutical product to medically prove to HHS how the vaccine caused his or her injury, where the science to understand vaccine injuries is not being done by the government department, HHS, tasked with this job.[92] As confirmed by the IOM, HHS has not conducted the basic science needed to even determine whether commonly claimed vaccine injuries are caused by vaccines.[93] It has failed to conduct even one properly sized study comparing vaccinated to

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[89] https://www.sec.gov/cgi-bin/own-disp?action=getowner&CIK=0000629884

[90] *See also* Bruesewitz v. Wyeth LLC, 562 U.S. 223 (2011)

[91] http://www.gao.gov/assets/670/667136.pdf

[92] See Sections II, III, IV, V, VI, and VII above.

[93] See Section IV above.

unvaccinated children, despite all the resources at its disposal.[94] It is no wonder a single injured child's claim faces a high likelihood of failure in the VICP.

Many parents, doctors and scientists, as well as politicians, are legitimately concerned about the process whereby vaccines are licensed, recommended, promoted and defended by the same department. This is not because of any conspiracy, or belief an insidious intent. Rather, this system eliminates the incentive, and in fact creates a disincentive for HHS and vaccine makers, to conduct research to uncover long term chronic conditions, including the immune and neurological system disorders, which can result from the current vaccine schedule.

The 1986 Act expressly provides that you, as the Secretary, have at least equal and arguably greater responsibility for vaccine safety than for vaccine promotion. (42 U.S.C. §§ 300aa-2, 300aa-27.) In accordance with this statutory responsibility:

(11) Please advise if you will:

a. **prohibit conflict waivers for members of HHS's vaccine committees (ACIP, VRBPAC, NVAC & ACCV)?**
b. **prohibit HHS vaccine committee members or HHS employees with duties involving vaccines from accepting any compensation from a vaccine maker for five years?**
c. **require that vaccine safety advocates comprise half of HHS's vaccine committees?**
d. **allocate toward vaccine safety an amount at least equal to 50% of HHS's budget for promoting/purchasing vaccines?**
e. **support the creation of a vaccine safety department independent of HHS?**
f. **support the repeal of the 1986 Act to the extent it grants immunity to pharmaceutical companies for injuries caused by their vaccine products?**

IX. Conclusion

HHS can do better. With hundreds of vaccines in the pipeline it must do better. Children susceptible to vaccine injury are as deserving of protection as any other child. Avoiding injury to these children is not only a moral and ethical duty, but will in fact strengthen the vaccine program. Every parent that does not witness their child suffer a serious reaction after vaccination, such as a seizure or paralysis, is another parent that will not add their voice to the growing chorus of parents opposed to HHS's vaccine program due to safety concerns.

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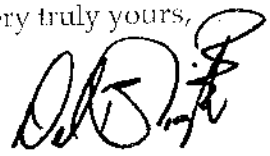
[94] See Section VII above.

Unless HHS performs its vital statutory obligations regarding vaccine safety, and until a frank conversation is possible regarding vaccine safety, children susceptible to vaccine injury will not be protected from such injuries. Nor will children injured by vaccines be able to access the services they need. We can do far better in protecting and serving children who are susceptible or succumb to serious injuries from vaccination. The first step in avoiding these harms and helping children already harmed is admitting there are deficiencies and working diligently to improve vaccine safety.

We respectfully request your attention to the important concerns outlined above and hope you agree that addressing these concerns is in everyone's best interest. These, in fact, reflect nothing more than what Congress already explicitly recognized when passing the 1986 Act: vaccines can and do cause serious injury and HHS needs to work diligently to identify and reduce these harms. If you would like to meet and discuss the foregoing, we would welcome that opportunity and hope to work cooperatively to address these issues.

If that is not possible, Congress, as a final resort to assure vaccine safety, authorized a "civil action ... against the Secretary where there is alleged a failure of the Secretary to perform any act or duty under" the 1986 Act. (42 U.S.C. § 300aa-31(a).) We are prepared to authorize such an action and this letter constitutes the notice required by 42 U.S.C. § 300aa-31(b). It is, however, our hope that the vaccine safety issues identified herein can be resolved cooperatively, with all interested parties working together toward the common goal of vaccine safety entrusted to HHS under the 1986 Act.

Very truly yours,



Del Bigtree

cc: See Appendix A.
Enclosures: Appendices A to C.

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Appendix B

Adverse Effects of Vaccines

Evidence and Causality

Committee to Review Adverse Effects of Vaccines

Board on Population Health and Public Health Practice

Kathleen Stratton, Andrew Ford, Erin Rusch, and Ellen Wright Clayton,
Editors

INSTITUTE OF MEDICINE
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Weight of Epidemiologic Evidence

The epidemiologic evidence is insufficient or absent to assess an association between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and ataxia.

Mechanistic Evidence

The committee identified one publication reporting the development of ataxia after the administration of DTaP vaccine. Kubota and Takahashi (2008) did not provide evidence of causality beyond a temporal relationship of 2 days between vaccine administration and development of cerebellar symptoms leading to a diagnosis of acute cerebellar ataxia. The publication did not contribute to the weight of mechanistic evidence.

Weight of Mechanistic Evidence

The committee assesses the mechanistic evidence regarding an association between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and ataxia as lacking.

Causality Conclusion

Conclusion 10.5: The evidence is inadequate to accept or reject a causal relationship between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and ataxia.

AUTISM

Epidemiologic Evidence

The committee reviewed one study to evaluate the risk of autism after the administration of DTaP vaccine. This one study (Geier and Geier, 2004) was not considered in the weight of epidemiologic evidence because it provided data from a passive surveillance system and lacked an unvaccinated comparison population.

Weight of Epidemiologic Evidence

The epidemiologic evidence is insufficient or absent to assess an association between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and autism.

Mechanistic Evidence

The committee did not identify literature reporting clinical, diagnostic, or experimental evidence of autism after the administration of vaccines containing diphtheria toxoid, tetanus toxoid, and acellular pertussis antigens alone or in combination.

Weight of Mechanistic Evidence

The committee assesses the mechanistic evidence regarding an association between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and autism as lacking.

Causality Conclusion

Conclusion 10.6: The evidence is inadequate to accept or reject a causal relationship between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccine and autism.

ACUTE DISSEMINATED ENCEPHALOMYELITIS

Epidemiologic Evidence

No studies were identified in the literature for the committee to evaluate the risk of acute disseminated encephalomyelitis (ADEM) after the administration of vaccines containing diphtheria toxoid, tetanus toxoid, or acellular pertussis antigens alone or in combination.

Weight of Epidemiologic Evidence

The epidemiologic evidence is insufficient or absent to assess an association between diphtheria toxoid–, tetanus toxoid–, or acellular pertussis–containing vaccines and ADEM.

Mechanistic Evidence

The committee identified five publications of ADEM developing after the administration of vaccines containing diphtheria toxoid and tetanus toxoid antigens alone or in combination. Four publications did not provide evidence beyond temporality, one of which was deemed too short based on the possible mechanisms involved (Abdul-Ghaffar and Achar, 1994; Bolukbasi and Ozmenoglu, 1999; Hamidon and Raymond, 2003; Rogalewski et al., 2007). In addition, Rogalewski et al. (2007) reported the administration of vaccines against hepatitis B, hepatitis A, and poliovirus in

Appendix C

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June 24, 2017

United States Department of Health & Human Services
National Institutes of Health
Food & Drug Administration
Centers for Disease Control & Prevention
200 Independence Avenue, S.W.
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Re: *Aluminum Adjuvants*

Dear Directors:

I am writing to you in regard to aluminum adjuvants in vaccines. This subject is one my laboratory works on intensively and therefore one where I feel that I have some expertise. In particular, we have studied the impact of aluminum adjuvants in animal models of neurological disease, including autism spectrum disorder (ASD). Our relevant studies on the general topic of aluminum neurotoxicity in general and specifically in regard to adjuvants are cited below.

These studies and the broader existing literature regarding aluminum toxicity, lead almost invariably to the conclusion that aluminum in any chemical form is always neurotoxic when administered to humans. Further, I am convinced that aluminum adjuvants in vaccines may contribute to neurological disorders across the lifespan. In adults, such adjuvant may induce macrophagic myofasciitis, a disease with neuropathological aspects. In children, there is growing evidence that aluminum adjuvants may disrupt developmental processes in the central nervous system and therefore contribute to ASD in susceptible children.

Despite the foregoing, the safety of aluminum adjuvants in vaccines has not been properly studied in humans even though, pursuant to the recommended vaccine schedule published by the Centers for Disease Control (CDC), a baby may be injected with up to 3,675 micrograms of aluminum adjuvant by six months of age.

In regard to the above, it is my belief that the CDC's claim on its website that "Vaccines Do Not Cause Autism" is wholly unsupported. Given this, I remain convinced that much more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is warranted and should be a research priority for the NIH and other funding bodies.

Yours sincerely,

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Relevant Publications (Shaw Laboratory)

1. Crepeaux G, Eidi H, David MO, Baba-Amer Y, Tzavara E, giros B, authier FJ, Exley C, Shaw CA, Cadusseau J, Gherardi RK. Non-linear dose-response of aluminium hydroxide adjuvant particles: Selective dose neurotoxicity. *Toxicology*. 375:48-57. (2016).

2. Crepeaux G, Eidi H, David M-O, Tzavara E, Giros B, Exley C, Curmi PA, Shaw CA, Gherardi RK, Cadusseau J. Highly delayed systemic translocation of aluminium-based adjuvant in CD1 mice following intramuscular injections. *J. Inorg. Biochem.* 152:199-205. (2015).

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June 15, 2017

United States Department of Health & Human Services
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Re: *Aluminum Adjuvants*

Dear Directors:

I am an expert in the field of aluminum adjuvants toxicity in humans and animal models. I have been working in this field since the initial description of the AI vaccine-induced macrophagic myofasciitis in 1998. Since that time I have written 40 peer-reviewed scientific publications and one book on this subject.

I strongly support the contention that aluminum adjuvants in vaccines may have a role in the etiology of autism spectrum disorder (ASD). My view is founded on a significant and burgeoning body of peer-reviewed scientific evidence which makes the link between ASD and exposure to aluminum through vaccinations and other sources. Examples of this literature from my own group are detailed below and I urge the HHS to take them into consideration in forming any future opinion on the safety of aluminum adjuvants in vaccines.

The Center for Disease Control's claim on its website that "Vaccines Do Not Cause Autism" is unsupported with respect to aluminum adjuvants and this claim stifles the important research to determine the safety of aluminum adjuvants used in vaccines. As an expert in the field of aluminum adjuvants and aluminum toxicity I solemnly declare that more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is essential and urgently required.

Yours very sincerely

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Selection of significant publications from our group in the field

Gherardi R. Toxic Story: deux ou trois vérités embarrassantes sur les adjuvants des vaccins. **Actes Sud** (publisher), Paris, 2016, 250 pages

Crépeaux G, Eidi H, David MO, Baba-Amer Y, Tzavara E, Giros B, Authier FJ, Exley C, Shaw CA, Cadusseau J, Gherardi RK. Non-linear dose-response of aluminium hydroxide adjuvant particles: Selective low dose neurotoxicity. **Toxicology**. 2017 Jan 15;375:48-57.

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The Center for Disease Control's claim on its website that "Vaccines Do Not Cause Autism" is unsupported with respect to aluminum adjuvants and this claim stifles the important research to determine the safety of aluminum adjuvants used in vaccines. As an expert in the field of aluminum adjuvants and aluminum toxicity I solemnly declare that more research on the role of aluminum adjuvant in vaccines and neurological disorders, including ASD, is essential and urgently required.

Yours faithfully

Christopher Exley PhD
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Honorary Professor, University of the Highlands and Islands

List of Recent, Relevant and Significant Publications From Our Group

Exley C, Siesjö P & Eriksson H (2010) The immunobiology of aluminium adjuvants: how do they really work? Trends in Immunology 31, 103-109.

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ATTACHMENT 2

Resume

Linda C. Hatzenbuehler, Ph.D., ABPP
306 S. 7th Ave.
Pocatello, ID 83201

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E-mail:hatzlind@isu.edu

EDUCATION

B.A., John Carroll University, Cleveland, Ohio, 1969, Psychology
M.A., Kent State University, Kent, Ohio, 1971, Clinical Psychology
Ph.D., Kent State University, Kent, Ohio, 1977, Clinical Psychology

PROFESSIONAL LICENSES AND BOARD CERTIFICATION:

Certified Psychosexual Evaluator (State of Idaho), 2008 to present.

Board Certification (Diploma in Forensics), American Board of Professional Psychology, 2000 to present.

Designated Examiner, State of Idaho, 1980 to present.

Psychologist, State of Idaho #126, 1979 to present.

EMPLOYMENT:

Private Practice, Clinical Psychology: Forensics

Emerita Professor of Psychology, Idaho State Univeristy

Idaho State University, 7/10 to 12/16 - Vice-Provost and Executive Dean, Division of Health Sciences and Professor of Psychology.

Idaho State University, 7/09 to 6/10 - Interim Associate Vice-President for Health Education and Professor of Psychology .

Idaho State University, 7/86 to 6/09 - Dean, Kasiska College of Health Professions and Professor of Psychology .

Idaho State University, 7/83 to 7/86 - Acting Associate Dean, College of Arts and Sciences and Associate Professor of Psychology.

Idaho State University, Department of Psychology, 9/76 to Present- Lecturer, 9/76-8/77; Assistant Professor, 9/77-7/82; Associate Professor, 9/82-6/2001; Professor, 7/2001-present.

Pocatello Women's Correctional Center, Staff Psychologist, October, 1994 - May, 1995 (15 hours/week), Psychological screening; behavior management programming; parole reports.

Department of Health & Welfare, Region VI Mental Health, 421 Memorial Drive, Pocatello, Idaho, 9/74 to 8/76 - Outpatient mental health provider and coordinator of children's mental health services for Region VI, Health and Welfare.

Child Development Center, 421 Memorial Drive, Pocatello, Idaho, 11/73 to 9/74. Supervisor of Clinical Services within the Division of Child Development.

Child Development Center, Leslie Avenue, Idaho Falls, Idaho, 11/72 to 8/73. Coordinator of Psychological Services at Child Development Center.

COMMUNITY MEMBERSHIPS:

Idaho Council on Suicide Prevention, Chair, 2014 to present

Psychology Licensure Board, 2014 to present

Idaho Mental Health Planning Council, Charter Member, 1987-present, Chair, 1997-1998; 2006-2009.

Region VI Behavioral Health Board Member, 1990 to present.

Idaho State Journal Reader's Advisory Board, 2010.

Idaho Council on Children's Mental Health, Certificate of Appointment, by Governor Dirk Kempthorne/Reappointed, Governor James Risch, 2003-2008.

National Association of Mental Health Planning and Advisory Councils (NAMHPAC), Alexandria, VA, President, 2001-2006; Secretary-Treasurer, 1998-2001.

Idaho Department of Health and Welfare Community Integration Committee, 2000-2004.

Bureau of Mental Health and Substance Abuse, PBS Documentary Advisory Committee, 1999.

Children's Mental Health Needs Assessment Executive Committee, 1999.

Idaho Health and Welfare Community Mental Health Initiative Oversight Committee, Chair, 1998.

Idaho Department of Health and Welfare Children's Mental Health Committee, 1997.

Past President, Board of Directors, South Park, Inc., (ICFMR facility).

CASA Board, 1992-1994.

Health West, Inc. (federally funded Community Health Center). Past Board Member.

ATTACHMENT 3

IDAHO BOARD OF HEALTH AND WELFARE
MINUTES
November 16, 2017

The Board of Health and Welfare convened at:
Pete T. Cenarrusa Building
450 W. State Street
Boise, Idaho 83720

BOARD MEMBERS PRESENT

Darrell Kerby, Chairman
Tom Stroschein, Vice-Chair
Russ Barron, Secretary
Dr. Richard Roberge
Wendy Jaquet
Stephen Weeg
Janet Penfold
Tammy Perkins
Senator Lee Heider
Jim Giuffré -- participating via phone

STAFF PRESENT

Lori Wolff, Deputy Director, FACS and Welfare Services
Kathie Brack, Special Assistant to the Director
Tamara Prisock, Division Administrator, Licensing and Certification
Ross Edmunds, Division Administrator, Behavioral Health
Matt Wimmer, Division Administrator, Medicaid
Elke Shaw-Tulloch, Division Administrator, Public Health
Dieuwke Spencer, Deputy Division Administrator, Public Health
Catherine Libby, Division Administrator, Operational Services
Julie Hammon, Division Administrator, Welfare
Jodi Osborn, Financial Executive Officer
Treena Clark, Policy, Planning & Communications Program Manager, Behavioral Health
Sabrina Brown, Foster Care Recruitment and Retention Program Specialist, FACS
Carissa Docker, LMSW, Child Welfare Funding Team Supervisor, Idaho ICAMA Administrator, FACS
John Cramer, EMS Program Manager, Public Health
Leslie Tengelsen, PhD DVM, State Public Health Veterinarian, Bureau of Communicable Disease Prevention, Public Health
Jacqueline Watson, Maternal Child Health Program Manager, Public Health
Steve Millward, Certified Family Homes Program Manager, Licensing and Certification
Eric Brown, Therapeutic and Residential Program Manager, Licensing and Certification
Niki Forbing-Orr, Public Information Officer
Chris Smith, Public Information Officer
Lynn Overman, Liaison to the Board

OTHERS PRESENT

Nicole McKay, Office of the Attorney General; Chief, Health and Human Services
Sara Stover, Legislative Services Office, Division of Financial Management, Analyst
Grace Lloyd – Boise State University Public Health Student
Raine Saunders – Health Freedom Idaho
Sara Walton Brady – Health Freedom Idaho
Miste Gardner Karlfeldt – Health Freedom Idaho

CALL TO ORDER

Following proper notice in accordance with Idaho Code, Section 67-2343, and pursuant to call by the Chairman, the meeting of the Idaho Board of Health and Welfare was called to order by Darrell Kerby, Chairman of the Board, at 8:07 a.m. Thursday, November 16, 2017, at the Pete T. Cenarrusa Bldg., 450 W. State Street, Boise, Idaho.
Chairman Kerby announced that the presentation from Matt Wimmer would be moved up, directly after the presentation of Ross Edmunds.

ROLL CALL

Russ Barron, Secretary, called the roll. Roll call showed **eight (8)** members present. With **six (6)** voting members present, Chairman Kerby declared a quorum. Absent but participating via phone was Jim Giuffré. Stephen Weeg arrived at 10:20am.

PUBLIC COMMENT PERIOD

Chairman Kerby opened the floor for public comment. Sara Walton Brady from Health Freedom Idaho described her experience with the Idaho Immunization Form and subsequent difficulty enrolling her son in school. She is attending the Board meeting to ask the Board to encourage the DHW to communicate with Public School Districts regarding parent ability to opt out of signing the form.
Director Barron indicated that at the last meeting held with the Education Department and Ms. Brady, they agreed to change the form, removing the statement "the parent acknowledges they may be putting their child and other children at risk of illness and possible death by refusing immunization". The new form has been emailed to Senator Heider and Senator Souza for their review. Director Barron clarified that the DHW creates the form, but does not have authority to require that schools use the form.
The form does not prohibit schools and principals from denying the enrollment of a non-immunized child. This is a matter Ms. Brady will need to discuss with the State Department of Education.
Dr. Roberge requested information regarding the number of children immunized in Idaho. Elke Shaw-Tulloch distributed a fact sheet to the Board. (See Attachment 1).
A copy of the revised immunization exemption form was provided to Ms. Brady.

ADOPTION OF MINUTES FROM BOARD MEETING ON AUGUST 17, 2017

Motion: Janet Penfold moved that the minutes of the August 17, 2017, Board meeting be adopted as prepared.

Second: Tom Stroschein

Roll Call Vote:

Ayes: **Jaquet, Korby, Stroschein, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

SUMMARIES OF DHW RULES AND LEGISLATION FOR THE 2018 LEGISLATURE

Tamara Prisock, Division Administrator, Division of Licensing and Certification, presented the summaries. Many rules will be on the agenda, some will not and the summary addressed those rules that were not on the agenda. The dockets are broken out by Division. Public participation in developing dockets is also noted. Wendy Jaquet requested that Board members be invited to attend hearings when the rules come before committees. She would also like to receive notice of the Department's week to present before JFAC.
Six (6) proposals are being presented to the 2018 Legislature, as referenced in the summary at the beginning of the Administrative Rules section.

BEHAVIORAL HEALTH UPDATE

Ross Edmunds, Division Administrator, Division of Behavioral Health:

The Jeff D Lawsuit settlement compliance is going well. This program crosses the divisions of FACS (Family and Community Services) and Welfare as well as Behavioral Health. The first phase completion deadline is summer 2020 and will provide better access to services for children with SED (Serious Emotional Disturbances). Federal funds are available to those who qualify for Medicaid on January 1, 2018, for a new class of eligible children who are 185% FPL (Federal Poverty Level) to 300% FPL. We are adding effective services and organization for delivery of those services. This is being coordinated with mental health and juvenile services.

$5.6 million was appropriated to service the felon probation program. To date, the program is not operational and funds are not being spent. The DHW will work with the IDOC in implementing contracts with mental health providers and providers who can provide medication to the probationer/parolee population. Medication availability has been a barrier. Behavioral Health is working with the Idaho Primary Care Association and Quality Healthcare Centers (QHC's) to deliver mental health and other services to probationers, so they have one place to receive all needed care. This will start in the Treasure Valley and be statewide by March 2018. A contract has just begun that will offer once per week psychotherapy sessions for all cases. This program

will require the full funding appropriation. The DHW is working with the IDOC to combine funding and have a single approach to the delivery of services.

Historically, people with serious and persistent mental illness (SPMI) have a hard time finding living spaces. People with SPMI have unpredictable behaviors and cannot live in Residential Assisted Living Facilities (RALF's). Repeat offenders have difficulty finding a place to live. State Hospitals must keep these individuals, but due to space, sometimes they are released to homeless shelters. HART (Homes with Adult Residential Treatment) will fill this housing/treatment gap; treatment is embedded with the living facility.

The Boise crisis center "Pathways" will open on December 8. This will be the 4th center. The DHW has a budget request this year for three additional crisis centers. The Governor's office has been very supportive. Region 2 has decided to reserve rooms in crisis hospitals instead of building a facility. Senator Heider visited the center in Twin Falls and reports it is very nice and always full. Ross indicated that the full appropriation will be utilized and data will be kept to determine how much more money will be required to fulfill state needs. Dr. Roberge reported that Region 3 is talking about opening a center, but officials want enough money to fund the center for 2 years before opening. There are robust efforts to do the same in Region 6 and Region 2.
The location for the next center will be a competitive process. All centers open with a 2-year state contract. At the end of the contract period, centers are required to submit a plan showing how they will become 50% self-funded. Region 7 has a crisis center that reached the 2-year funding mark. They submitted a plan and projected it will take 4 years to get to full self-sufficiency. They will seek 80% funding from the State up to that time. An estimated $450,000 per quarter has been saved at the Coeur d'Alene center alone. Feedback from law enforcement and families confirm the centers are highly successful.
Funding is also being requested for Recovery Centers to deal with the Opioid Crisis.
Mr. Kerby thanked Ross for his enthusiasm and energy supporting this program.

MEDICAID UPDATE

Matt Wimmer, Division Administrator, Division of Medicaid:

A handout in the binders outlined the updates. (See Attachment 2).

The DHW partners with Optum for Youth Empowerment Services (YES) and Homes with Adult Residential Treatment (HART).

We will follow the pattern of other states to develop Regional Care Organizations, starting in the Treasure Valley, for providers to collaborate for better quality of care to reduce budget needs.

The Medicaid Division will be asking the 2018 Legislature to approve rate increases for Rehabilitation Facility providers and Personal Care Assistance agencies.

APPROVAL OF TEMPORARY AND PENDING RULES

Behavioral Health, Behavioral Health Programs
Docket No.16-0715-1701

Presenter: Treena Clark

Treena Clark, Policy, Planning & Communications Program Manager, Division of Behavioral Health, presented the Behavioral Health Programs rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Behavioral Health Programs" presented under Docket No. 16-0715-1701, with an effective date of July 1, 2018.

Second: Janet Penfold

Vote: Ayes: **Jaquet, Kerby, Stroschein, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Behavioral Health, Substance Use Disorders Services
Docket No. 16-0717-1701

Presenter: Treena Clark

Treena Clark, Policy, Planning & Communications Program Manager, Division of Behavioral Health, presented the Substance Use Disorders Services rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Substance Use Disorders Services" presented under Docket No. 16-0717-1701, with an effective date of July 1, 2018.

Second: Janet Penfold

Vote: Ayes: **Jaquet, Kerby, Stroschein, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Behavioral Health, Rules and Minimum Standards Governing Non-Hospital, Medically-Monitored Detoxification/Mental health Diversion Units
Docket No. 16-0750-1701

Presenter: Treena Clark

Treena Clark, Policy, Planning & Communications Program Manager, Division of Behavioral Health, presented the Rules and Minimum Standards Governing Non-Hospital, Medically-Monitored Detoxification/Mental Health Diversion Units rule docket for the Board's approval.

Motion: Tom Stroschein moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Minimum Standards for Non-Hospital, Medically-Monitored Detoxification/Mental Health Diversion Units" presented under Docket No. 16-0750-1701, with an effective date of July 1, 2018.

Second: Janet Penfold

Vote: Ayes: **Jaquet, Kerby, Stroschein, Penfold, Roberge, Giuffré**
Nays: **None**.

Motion carried.

COMMENTS FROM BOARD MEMBERS

A proposed meeting schedule for 2018 was discussed. (See Attachment 3).

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare Meeting adopt dates for 2018 meetings, with changes as follows:

February 22
May 17
August 23
November 15

Second: Robert Roberge

Vote: Ayes: **Jaquet, Kerby, Stroschein, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

WELFARE/ FAMILY AND COMMUNITY SERVICES (FACS) UPDATE

Lori Wolff, Deputy Director of Welfare and Family and Community Services (FACS):

Lori reported that the Division of Welfare is working on eligibility for Advance Premium Tax Credits for Open Enrollment of the Insurance Exchange, which ends December 15. The Cost Share Reduction (CSR) was removed by the federal government and has created additional challenges, but the enrollment process is going well and is improving each year.

Child Support is in the 2nd year of funding a 3-year improvement to its IT system. This is the 1st year of a system development upgrade to the computer program. The cost to convert the system is $24 million, versus $80 million for replacement. The DHW will ask for the final year of funding to complete the upgrade. With the 3-year contract, most of the upgrades will be done. Strategies are already in place to determine how to continue system upgrades. Updating for the ICARE program will be a three to five-year project.

Family and Community Services (FACS) also requires a system modernization. The current code is being updated and staff are looking at cost effective ways to modernize the system. There is a need to reduce administrative work for caseworkers so they have more time to spend with children and families. Use of technological advances could assist with this goal. Funding is also being asked for 13 additional positions. Three positions will support the business office. Staffing issues should not be a factor in completing safety assessments, and there has been a steady increase in assessment need. More calls are related to the opioid crisis – especially for newborns in hospitals. The Child Welfare Executive Steering Committee has been an effective means of developing ideas and creating interaction with all stakeholders. The Interim Committee has also been effective in determining challenges and coming up with ideas.

The Work in Training program for Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) tries to get individuals into the work force. Most participants have a high school education, so the jobs they qualify for are low-paying and do not relieve their need for assistance. The federal government offers match dollars to support community organizations to train these individuals. The first 3 partners are now receiving referrals. The goal is to involve community colleges so individuals will be able to get technical and associates degrees. North Idaho College is a participating school.

BOARD CONCURRENCE OF APPOINTMENT

Director Barron introduced Miren Unsworth in her new position as the Division Administrator of the FACS division. She is a great strength to the Department. Her Curriculum Vitae was reviewed by Board Members, and she was asked to tell the Board about her experience and passion for the FACS division. (See Attachment 4).

- Miren was a child welfare social worker in Boise for 13 years. In addition, her mom retired after 40 years as a social worker. Miren had many positive interactions throughout the community when she was out with her mom that made her want to be a social worker. She attended Idaho State University and Portland State University to complete her

bachelor's and master's degrees, respectively. Her goal is to continue the work of existing programs and investigate new ideas and methodologies to further the programs positively.

Motion: Stephen Weeg moved that the Board of Health and Welfare approve the appointment of Miren Unsworth as Division Administrator of Family and Community Services (FACS) for the Department of Health and Welfare.

Second: Wendy Jaquet

Vote: Ayes: **Jaquet, Kerby, Stroschein, Penfold, Weeg, Roberge, Giuffré**
Nays: **None**

Motion carried.

FACS, Child and Family Services
Docket No. 16-0601-1701

Presenter: Sabrina Brown

Sabrina Brown, Foster Care Recruitment and Retention Program Specialist, Division of Family and Children's Services, presented the "Child and Family Services" rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for "Child and Family Services" presented under Docket No. 16-0601-1701, effective Sine Die, 2018.

Second: Tom Stroschein

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

FACS, Child and Family Services
Docket No. 16-0601-1702

Presenter: Carissa Decker

Carissa Decker, LMSW, Child Welfare Funding Team Supervisor, Idaho ICAMA Administrator, Division of Family and Children's Services, presented the "Child and Family Services" rule docket for the Board's approval.

Motion: Tom Stroschein moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Child and Family Services" presented under Docket No. 16-0601-1702, effective Sine Die, 2018.

Second: Janet Penfold

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

PUBLIC HEALTH UPDATE

Elke Shaw-Tulloch, Division Administrator, Public Health:

A handout of Idaho's response to the Opioid crisis, with figures and treatment was provided. (See Attachment 5). Because this crisis crosses many divisions, the goal is to work with an interdisciplinary team. Wendy Jaquet suggested that numbers rather than percentages may give a clearer picture of the problem. West Virginia has a pilot program for Medicaid, which does not reimburse prescriptions for opioids.

There was some discussion about current laws and lack of funding for coroners to perform autopsies. Barriers include no information regarding opioids and not enough funding for toxicological screens. Reportedly, some coroners have only enough funding to do a limited number of autopsies per year, if they are able. In Idaho, most coroners are not able to perform autopsies locally because more sophisticated technology and a trained pathologist are needed. Approximately thirty counties send bodies for autopsies to the Ada County Coroner in Boise. The expenses associated with transporting a body to Boise reduces the frequency of autopsies. County coroners would like to see this changed.

The Expanded Access Program, also called a compassionate use program, for the administration of the drug Epidiolex to children with intractable seizures has been successful and will continue. The pharmaceutical company that manufactures Epidiolex has applied to the Federal Drug Administration (FDA) to fast-track the drug, which is reported to take approximately eight months. After its approval by the FDA, the Drug Enforcement Agency (DEA) will change the scheduling of the drug because it is Cannabis based, which currently makes it a schedule I drug. State law will also need to be changed for the drug to be made commercially available, but the Board of Pharmacy may have the ability to do this with their existing authority.

Immunizations: TRICARE, the insurer for military families, previously was not able to pay into Idaho's Immunization Assessment Fund. The Immunization Program has been working with the

Department of Defense, other states with assessment funds, and a contractor to find a solution so TRICARE can pay into the funds. A solution has been found. TRICARE has also agreed to pay Idaho in arrears for the money the general fund has paid to cover vaccines for these children for the past six or so years. Idaho has received a check for $3,557,185.47 to cover both the arrears and the assessment for the current year.
A handout on immunization rates in Idaho was distributed by Elke Shaw-Tulloch. (See Attachment 6). Idaho is above the national average on immunization rates and has now reached the Centers for Disease Control (CDC) immunization goals for the first time. All data are received in aggregate from public schools (no individual data are shared) by the Division of Public Health. Homeschooling immunizations are not reported.
The flu vaccine for this year seems to be effective. There has been one outbreak reported in a nursing home. One death has already occurred.

Public Health, Emergency Medical Services (EMS), Account III Grants (New Chapter)
Docket No. 16-0104-1701

Presenter: John Cramer

John Cramer, EMS Program Manager, Division of Public Health, presented the "EMS Account III Grants (New Chapter)" rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Rules Governing EMS Account III Grants (New Chapter)" presented under Docket No. 16-0104-1701, with an effective date of July 1, 2018.

Second: Stephen Weeg

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Public Health, Emergency Medical Services (EMS), Account III Grants (Repeal of Chapter)
Docket No. 16-0204-1701

Presenter: John Cramer

John Cramer, EMS Program Manager, Division of Public Health, presented the "EMS Account III Grants (Repeal of Chapter)" rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Rules Governing EMS Account III Grants (Repeal of Chapter)" presented under Docket No. 16-0204-1701, with an effective date of July 1, 2018.

Second: Tom Stroschein

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Public Health, Idaho Reportable Diseases
Docket No. 16-0210-1701

Presenter: Leslie Tengelsen

Leslie Tengelsen, PhD DVM, State Public Health Veterinarian, Bureau of Communicable Disease Prevention, Division of Public Health, presented the "Idaho Reportable Diseases" rule docket for the Board's approval.

Motion: Tom Stroschein moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Idaho Reportable Diseases" presented under Docket No. 16-0210-1701, effective Sine Die, 2018.

Second: Wendy Jaquet

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Public Health, Procedures and Testing to be Performed on Newborn Infants
Docket No. 16-0212-1701

Presenter: Jacqueline Watson

Jacqueline Watson, Newborn Screening Program Manager, Division of Public Health, presented the "Procedures and Testing to be Performed on Newborn Infants" rule docket for the Board's approval.

Motion: Stephen Weeg moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Procedures and Testing to be Performed on Newborn Infants" presented under Docket No. 16-0212-1701, with an effective date of July 1, 2018.

Second: Janet Penfold

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Operational Services, Behavioral Health, Licensing, Medicaid, and Welfare, Contested Case Proceedings & Declaratory Rulings
Docket No. 16-0503-1701

Presenter: Catherine Libby

Catherine Libby, Division Administrator, Division of Operational Services, presented the "Contested Case Proceedings & Declaratory Rulings" rule docket for the Board's approval.

Motion: Janet Penfold moved that the Idaho Board of Health and Welfare adopt the "Pending" and "Temporary" rules for the "Rules Governing Contested Case Proceedings and Declaratory Rulings" presented under Docket No. 16-0503-1701, with an effective date of January 1, 2018.

Second: Stephen Weeg

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Licensing and Certification, Certified Family Homes
Docket No. 16-0319-1701

Presenter: Steve Millward

Steve Millward, Certified Family Homes Program Manager, Division of Licensing and Certification, presented the "Certified Family Homes" rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Rules Governing Certified Family Homes" presented under Docket No. 16-0319-1701, with an effective date of July 1, 2018.

Second: Janet Penfold

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

IDAHO HEALTHCARE PLAN

Russ Barron, Director of the Department of Health and Welfare, introduced the Idaho Health Care Plan which is designed to provide coverage for the Gap population and reduce premiums on the insurance exchange. (See Attachment 7). Lori Wolff gave a PowerPoint presentation to the Board describing the two CMS waivers (1332 and 1115) in the plan. (See Attachment 8).

Licensing and Certification, Residential Habilitation Agencies (Rewrite of Chapter) Docket No. 16-0417-1702

Presenter: Eric Brown

Eric Brown, Therapeutic and Residential Program Manager, Division of Licensing and Certification, presented the "Residential Habilitation Agencies (Rewrite of Chapter)" rule docket for the Board's approval.

Motion: Stephen Weeg moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Rules Governing Residential Habilitation Agencies (Rewrite of Chapter)" presented under Docket No. 16-0417-1702, with an effective date of July 1, 2018.

Second: Wendy Jaquet

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

Licensing and Certification, Residential Habilitation Agencies (Repeal of Chapter) Docket No. 16-0417-1701

Presenter: Eric Brown

Eric Brown, Therapeutic and Residential Program Manager, Division of Licensing and Certification, presented the "Residential Habilitation Agencies (Repeal of Chapter)" rule docket for the Board's approval.

Motion: Wendy Jaquet moved that the Idaho Board of Health and Welfare adopt the "Pending" rules for the "Rules Governing Residential Habilitation Agencies (Rewrite of Chapter)" presented under Docket No. 16-0417-1701, with an effective date of July 1, 2018.

Second: Tom Stroschein

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

BUDGET REQUEST UPDATE

Jodi Osborn, Financial Executive Officer:

Jodi provided two handouts with budget proposals for FY 2019. (See Attachments 9 & 10). Funds for the opioid crisis are utilized by Behavioral Health in the crisis centers. Funds will be derived from provider rate increases for substance abuse. With the loss of Millennium Fund moneys which will now potentially support the Idaho Health Care Plan, the DHW will propose a $100 increase for the tobacco permits program. Approximately 1,600 permits are issued annually across the state.
Mr. Stroschein also expressed his support for the additional funding request to expand the Youth Suicide Prevention program to elementary school children.

OFFICER ELECTION FOR BOARD CHAIR

Idaho Code requires the annual election of a Board Chair.

Motion: Wendy Jaquet nominated Darrell Kerby for the Chair of the Idaho Board of Health and Welfare.

Second: Robert Roberge

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

OFFICER ELECTION FOR BOARD VICE-CHAIR

Idaho Code requires the annual election of a Board Vice-Chair.

Motion: Wendy Jaquet nominated Commissioner Tom Stroschein for the Vice-Chair of the Idaho Board of Health and Welfare.

Second: Robert Roberge

Vote: Ayes: **Jaquet, Kerby, Stroschein, Weeg, Penfold, Roberge, Giuffré**
Nays: **None**

Motion carried.

DIRECTOR'S UPDATE

Director Barron updated the Board regarding the Non-Emergency Medical Transportation (NEMT) contract. The current contract holder, Veyo, has had performance concerns. The DHW's Medicaid staff have met and corresponded with Veyo about needed improvements. Veyo has ended the contract and the Department accepted the termination offer, with an effective service end date of March 5, 2018. The Department of Administration/Division of Purchasing is going through the process of vetting the next top three bidders for a new contract. Medicaid will likely create a committee or team to monitor the transition to a new vendor. The team will include drivers, patients, doctors and advocates.

Southwest Idaho Treatment Center (SWITC) has received a new complaint. A survey team found the claim was unsubstantiated. Challenges remain at the SWITC due to patients who are a danger to staff and property. The facility needs to be a safe place for employees to end the high turnover rate. While it needs to be "secure", there are no guidelines on what that is or how to obtain it. There are no effective models from other states. Staff will work with the Administrative Rules Unit (ARU) to develop an outline for rules to present at the next Board meeting in February 2018. The Director also wants to re-constitute an Advisory Board for SWITC.

The DHW provided a rate model to the Idaho Association of Community Providers (IACP), which was not well received. The DHW has a budget increase request in the 2018 budget. Staff will meet with members of IACP later this month to discuss the request. Surveys of Assisted Living Facilities show they may not have the services needed to adequately cover the needs of patients. One issue has been a competitive pay rate for qualified nurses. The Office of Performance Evaluations (OPE) is conducting a study on the Licensing and Certification Bureau (L&C). Previously, inspections delayed certification, but the process now takes about 90 days. Reports from the study could be an opportunity to educate facilities and the public on the licensing and certification process.

ADJOURNMENT

The next meeting of the Idaho Board of Health and Welfare is scheduled to be held February 22, 2018. There being no further business to come before the Board, Chairman Kerby adjourned the meeting at 2:31 p.m.

Respectfully signed and submitted by:

Darrell Kerby, Chairman

Russell S. Barron, Secretary

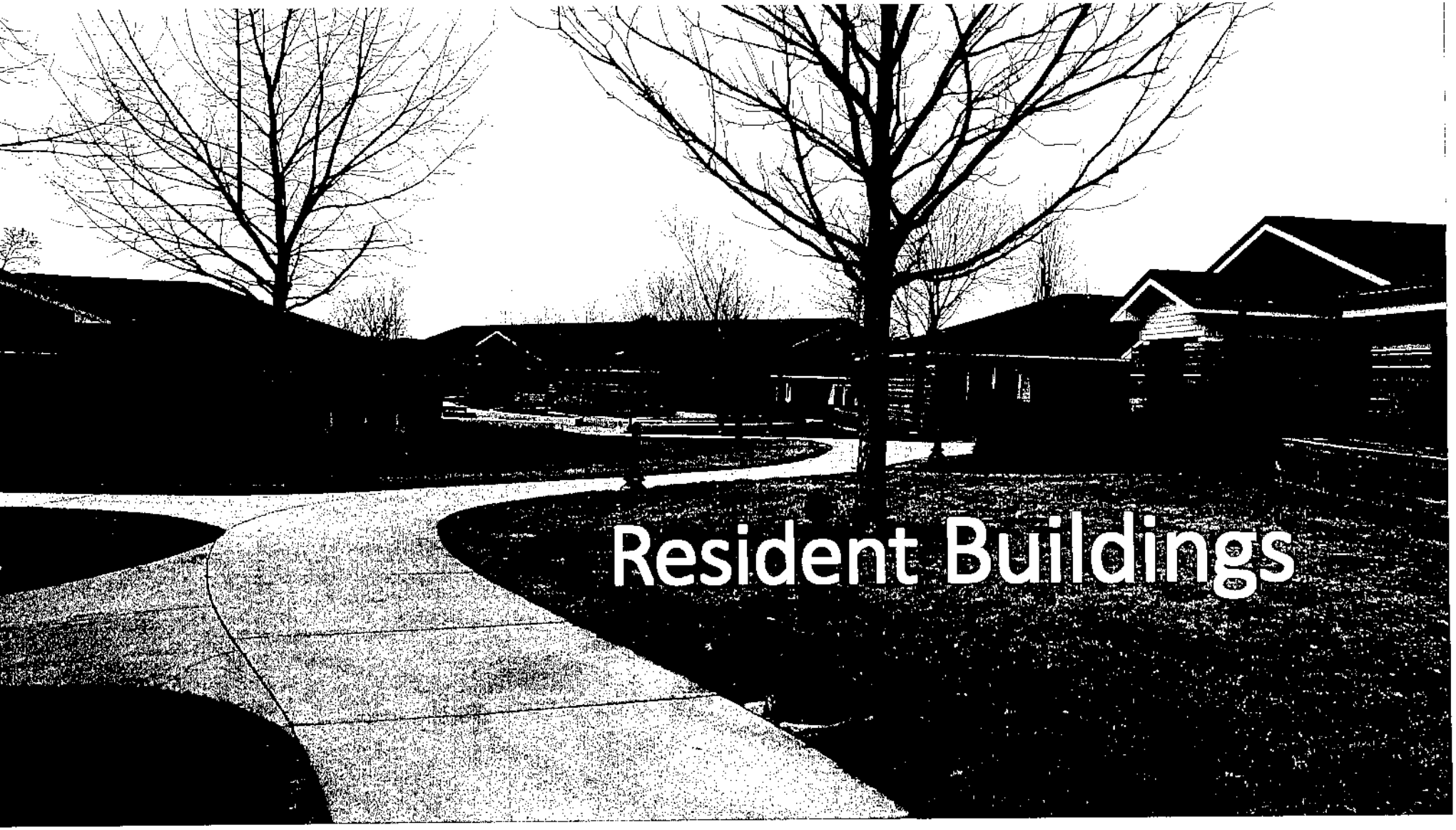
Lynn Overman, Liaison to the Board

ATTACHMENT 4

[redacted]

[redacted]

Southwest Idaho Treatment Center


Resident Buildings


Pine Building


Client Rooms


Common Area


Common Area

LEGISLATURE OF THE STATE OF IDAHO
Sixty-fourth Legislature First Regular Session - 2017

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 222

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO THE SECURE TREATMENT FACILITY ACT; AMENDING TITLE 66, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 14, TITLE 66, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO PROVIDE AUTHORITY, TO DEFINE TERMS, TO PROVIDE CRITERIA TO QUALIFY FOR ADMISSION TO A CERTAIN FACILITY, TO PROVIDE FOR DISPOSITION AND REDISPOSITION TO AND DISCHARGE FROM THE FACILITY, TO ESTABLISH RIGHTS OF THOSE ADMITTED TO THE FACILITY AND TO PROVIDE FOR CERTAIN TREATMENT; AND DECLARING AN EMERGENCY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Title 66, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 14, Title 66, Idaho Code, and to read as follows:

CHAPTER 14
SECURE TREATMENT FACILITY ACT

66-1401. SHORT TITLE. This chapter shall be known and may be cited as the "Secure Treatment Facility Act."

66-1402. AUTHORITY. (1) The department of health and welfare shall have the power to establish, operate and maintain a secure treatment facility for persons with an intellectual or developmental disability who pose a substantial threat to the safety of others. These persons may also have co-occurring mental illness requiring diagnostic services and treatment in a secure facility. The facility shall be identifiably separate from other facilities managed by the department of health and welfare for persons with an intellectual or a developmental disability. The provisions of this chapter shall be liberally construed to accomplish these purposes.

(2) The director of the department of health and welfare or the director's designee shall have the authority to make rules for the governance of the facility and program consistent with this chapter.

(3) When a person is the subject of a court order pursuant to section 66-1404, Idaho Code, for admission to a secure facility, the department may disposition the person to the facility or another appropriate placement.

(4) The department of health and welfare division of licensing and certification will develop a license and survey process for the facility.

(5) The provisions of chapter 4, title 66, Idaho Code, apply unless otherwise specified.

66-1403. DEFINITIONS. As used in this chapter:

(1) "Administrator" means the administrator of the secure treatment facility.

(2) "Adult" means an individual eighteen (18) years of age or older.

(3) "Department" means the Idaho department of health and welfare.
(4) "Developmental disability" means a developmental disability as defined in section 66-402, Idaho Code, or an intellectual disability as defined in section 73-114, Idaho Code.
(5) "Director" means the director of the department.
(6) "Dual diagnosis" means the coexistence of the symptoms of both intellectual or developmental disabilities and mental health issues.
(7) "Facility" or "secure treatment facility" means the facility to be operated by the department to fulfill the purposes of this chapter. The facility shall, at a minimum, include:
(a) Locked, fenced and enclosed grounds accessible only to persons, staff and authorized individuals;
(b) Locked residential units;
(c) Bedroom and building exit alarms;
(d) Monitoring cameras in all common areas;
(e) Modified interiors to reduce risk of suicide; and
(f) Restricted access to items that could be used as weapons.
(8) "Person" means an individual subject to judicial proceedings authorized by the provisions of this chapter who is being considered for disposition or is admitted and dispositioned into the secure treatment facility.
(9) "Serious mental illness" means any of the following psychiatric illnesses as defined by the American psychiatric association in the diagnostic and statistical manual of mental disorders (DSM):
(a) Schizophrenia spectrum and other related disorders;
(b) Paranoia and other psychotic disorders;
(c) Bipolar and other related disorders;
(d) Depressive disorders;
(e) Trauma and stressor-related disorders;
(f) Anxiety disorders;
(g) Obsessive-compulsive and other related disorders;
(h) Dissociative disorders; and
(i) Personality disorders.
(10) "Substantial threat to the safety of others" means the presentation, by a person, of a substantial risk to physically harm other individuals, as manifested by evidence of violent behavior.

66-1404. CRITERIA FOR ADMISSION. (1) To be admitted to the facility, a person must:
(a) Have a primary diagnosis of developmental disability, as determined by the department, and a diagnosis of serious mental illness;
(b) Be an adult;
(c) Meet one (1) of the following grounds:
(i) The person is charged with a crime and is committed to the department to undergo evaluation or treatment for competency to stand trial in conformance with chapter 2, title 18, Idaho Code; or
(ii) The person is civilly committed to the custody of the department in conformance with chapter 4, title 66, Idaho Code; and
(d) Be found, by a court, to present a substantial threat to the safety of others if not evaluated or treated in a secure facility.

(2) If the court finds that the person meets the criteria for admission, the court shall, as part of the commitment to the department, order that the person is appropriate to be admitted to the facility.

66-1405. DISPOSITION, REDISPOSITION AND DISCHARGE. (1) Disposition. Disposition of a person into the facility shall be determined solely by the director or the director's designee. In considering whether a person should be dispositioned to the facility, the director or the director's designee may consider any relevant factor including, but not limited to, the following:

(a) Whether less-restrictive alternatives, including services provided in community residential facilities or other community settings that would offer an opportunity for improvement of the condition, have been judged to be inappropriate;

(b) Whether admission of the person would cause overcrowding of the facility; and

(c) Whether the facility is unable to provide appropriate care or treatment for the person.

(2) Transportation. Upon admission, the person shall be transported to the facility in conformance with chapter 2, title 18, Idaho Code, or chapter 4, title 66, Idaho Code.

(3) Redisposition and notice.

(a) After placement in the facility, the director or the director's designee may redisposition the person to a less-restrictive facility. If the person was committed to the department under title 18, Idaho Code, notice of change of disposition shall be filed with the committing court. If the person was committed to the department under this title, notice of change in disposition shall be given in accordance with section 66-407, Idaho Code.

(b) A judicial order that a person is appropriate to be admitted to the facility constitutes continuing authorization for the department to redisposition a person back into the facility as long as the commitment to the department continues under chapter 2, title 18, Idaho Code, or chapter 4, title 66, Idaho Code. If the director or the director's designee has dispositioned a person to a less-restrictive facility and later redispositions the person to the secure treatment facility, the person may appeal the redisposition to the committing court within thirty (30) days' notice of the change in disposition. The court shall consider the following admission criteria:

(i) Whether the person continues to present a substantial threat to the safety of others if not evaluated or treated in a secure facility; and

(ii) Whether its order that the person may be admitted to a secure treatment facility continues to be appropriate.

If the court finds that the person does not meet either admission criteria, the department shall disposition the person to a placement other than the facility, or discharge the person from commitment in accordance with chapter 2, title 18, Idaho Code, or chapter 4, title 66, Idaho Code.

(4) Discharge. The director or the director's designee shall review the person's progress every ninety (90) days to determine whether the person continues to meet the program criteria. If the person no longer meets the program criteria as provided in this chapter, the director or the director's designee shall discharge the person from the facility. The director or the director's designee may discharge the person from the commitment under chapter 2, title 18, Idaho Code, or chapter 4, title 66, Idaho Code, or redispose the person to a less-restrictive setting. If the person is discharged from commitment, notice shall be given as allowed by law authorizing the commitment.

66-1406. RIGHTS OF PERSONS. (1) All persons shall be accorded those civil rights provided by chapter 4, title 66, Idaho Code, except as otherwise provided in this section.

(2) Access to attorney and advocacy. Every person in the facility shall at all times have the right to visit and be visited by or to communicate by sealed mail, telephone, or otherwise with the person's attorney, an employee at the attorney's firm or a representative of the state protection and advocacy system. Each person shall have reasonable access to letter-writing material and postage for this purpose.

(3) Court order. The department may limit civil rights if and as provided in a court order.

(4) Limitations on communication, visitation and property in the facility. Except as provided in subsection (2) of this section, the department may limit a person's rights to communicate with individuals inside or outside the facility or to receive visitors or associate freely with individuals, and to keep and use the person's own personal possessions, only if the following occurs:

(a) The decision to limit such person's rights is a clinical decision made as part of the person's individual treatment plan developed in accordance with chapter 4, title 66, Idaho Code;

(b) A statement explaining the reasons for such limitations shall immediately be entered in the person's treatment record;

(c) Copies of such statement shall be sent to the person's attorney, guardian, and the person's spouse, adult next of kin, or friend, if any; and

(d) The person may appeal the treatment decisions that limit the person's rights under this section to the department's human rights committee within thirty (30) days.

(5) The use of mechanical restraints during the transportation to or from any facility must be in compliance with section 66-345, Idaho Code.

66-1407. TREATMENT. (1) The director or the director's designee shall have the power to develop appropriate standards and rules for treatment of persons in the facility. It shall be the responsibility of the director or the director's designee to implement those standards.

(2) The relative risks and benefits of specific modes of treatment contained in such plans shall be explained to each person or the spouse, guardian, adult next of kin or friend of the person, to the extent allowable by law.

(3) The ability of a person to make informed decisions as to treatment will be made in accordance with a person's commitment to the department as provided in chapter 2, title 18, Idaho Code, or chapter 4, title 66, Idaho Code.

(4) Restraints may be used only when a person poses an imminent risk of physical harm to self or others and restraints are the least-restrictive intervention that would achieve safety.

(5) The person shall be entitled to be diagnosed, cared for and treated in a manner consistent with the person's legal rights and in a manner no more restrictive than necessary for the person's protection and the protection of others for a period no longer than reasonably necessary for diagnosis, care, treatment and protection.

SECTION 2. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval.

ATTACHMENT 6

MOTIONS
By
BOARD OF HEALTH AND WELFARE

MEETING DATE: **February 22, 2018**

Licensing and Certification: Secure Treatment Facility for People with Intellectual Disabilities
Docket No. 16-0315-1801

I, James Giuffre, move that the Idaho Board of Health and Welfare adopt the "Temporary" rules for "Secure Treatment Facility for People with Intellectual Disabilities", presented under Docket No. 16-0315-1801, effective February 22, 2018.

MOTION BY: Jim Giuffre

SECONDED BY: Tom Stroschein

VOTE: Voice Vote: _____ Roll Call: _____

	Aye	*Nay*	*Absent*	*Abstain*
Mr. Kerby	✓			
Mr. Giuffre	✓			
Ms. Hatzenbuehler	✓			
Dr. Roberge	✓			
Mr. Stroschein	✓			
Ms. Jaquet	✓			

CONVENE AT: _____ ADJOURN AT: _____

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER- Governor
RICHARD M. ARMSTRONG - Director

ADMINISTRATIVE PROCEDURES SECTION
Division of Human Resources
450 West State Street, 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
PHONE 208-334-5564
FAX 208-334-6558

DECLARATION OF TEMPORARY RULEMAKING
BY THE BOARD OF HEALTH AND WELFARE
CONCERNING: DOCKET NO. 16-0315-1801

Pursuant to the authority granted to the Board of Health and Welfare in Title 56, Chapter 10, and Title 66, Chapter 14, Idaho Code, and under the provisions for temporary rulemaking contained in Section 67-5226, Idaho Code, I declare that the following Idaho Department of Health and Welfare rules contained in IDAPA 16, Title 03, Chapter 15, "Secure Treatment Facility for People with Intellectual Disabilities," are hereby:

SECTION AFFECTED	ACTION TAKEN
All	Adopt New Chapter

I hereby certify that these actions have been made in compliance with Title 67, Chapter 52, Idaho Code.

February 22, 2018
Date

Darrell Kerby, Chairman

STATE OF IDAHO)
) ss.
County of Ada)

On this 22nd of February, 2018, before me, the undersigned, a Notary Public in and for said State, personally appeared *Darrell Kerby, Chairman,* known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed the same.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal the day and year in this certificate first above written.

JANICE HANKE NOTARY PUBLIC STATE OF IDAHO

Janice Hanke
Notary Public for Idaho
Residing at: Ada County
Expires: 08/08/2019

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.15 - SECURE TREATMENT FACILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES
DOCKET NO. 16-0315-1801

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is February 22, 2018.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-1003, 56-1004, 56-1004A, 56-1005, 56-1009, 66-1402, and 66-1407, Idaho Code; and H0222 (2017).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than April 18, 2018.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule sets standards and provides the licensing requirements and the criteria for use of restrictive or secure features at this type of facility, including staffing, treatment requirements, and enforcement remedies. This rule will also provide and address client rights. Required sections will be added to meet the APA and rules of the Office of the Administrative Rules Coordinator.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This rule is a temporary rule and needs to be in place as soon as possible. The Department has held informal meetings with individual groups of stakeholders to receive input concerning the secure treatment facility licensing standards and with advocacy groups to ensure protections of the rights and health and safety of people who live and work at the facility.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

The cost for licensing and surveying this facility for SFY 2018 is approximately $2,000.00 in state general funds, which can be covered with the existing budget in the Division of Licensing and Certification. All funds for this facility are state general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the January 3, 2018, Idaho Administrative Bulletin, Volume 18-1, pages 81 and 82.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following documents are being incorporated by reference in this chapter of rules to give them the force and effect of law. The documents are not being reprinted due to the length, format, and/or the cost for republication.

National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, 2012 edition. The following

document is incorporated by reference in these rules: National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, NFPA 101 for "New Healthcare Occupancies" published by the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471. A copy is available for review at the Department's Division of Licensing and Certification located at 3232 Elder Street, Boise, Idaho 83705. The NFPA 101: Life Safety Code may be accessed online at: https://www.nfpa.org.

Idaho Diet Manual, 11th edition. This manual is available from the Idaho Dietetic Association, online at http://eatrightidaho.org.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Tamara Prisock, 208-364-1959.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before April 25, 2018.

DATED this ____ day of _____, 2018.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov e-mail

THE FOLLOWING IS THE TEMPORARY AND PROPOSED TEXT OF DOCKET NO. 16-0315-1801

IDAPA 16
TITLE 03
CHAPTER 15

16.03.15 - SECURE TREATMENT FACILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES

000. LEGAL AUTHORITY.
The Board of Health and Welfare is authorized according to Section 66-1407, Idaho Code, to develop appropriate standards and rules for treatment of persons in the facility for people with intellectual disabilities. According to Sections 56-1003, 56-1004, 56-1004A, 56-1005, 56-1009, and 66-1402, Idaho Code, the Department and the Board of Health and Welfare have prescribed powers and duties to provide for the administration and enforcement of Department programs and rules. (2-22-18)T

001. TITLE AND SCOPE.

01. Title. The title of this chapter of rules is IDAPA 16.03.15, "Secure Treatment Facility for People with Intellectual Disabilities" (2-22-18)T

02. Scope. These rules include the licensing standards and requirements for the administration of the facility for treatment of persons with intellectual or developmental disability under Title 66 Chapter 14, Idaho Code. The secure treatment facility must be operated by the Department and identifiably separate from other facilities

operated by the Department for persons with intellectual or developmental disabilities or for persons with severe and persistent mental illness. (2-22-18)T

002. WRITTEN INTERPRETATIONS.
According to with Section 67-5201(19)(b)(iv), Idaho Code, the Department's Division of Licensing and Certification may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. (2-22-18)T

003. ADMINISTRATIVE APPEALS.
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (2-22-18)T

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (2-22-18)T

01. National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, 2012 edition. The following document is incorporated by reference in these rules: National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, NFPA 101 for "New Healthcare Occupancies" published by the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471. A copy is available for review at the Department's Division of Licensing and Certification located at 3232 Elder Street, Boise, Idaho 83705. The NFPA 101: Life Safety Code may be accessed online at: https://www.nfpa.org. (2-22-18)T

02. Idaho Diet Manual, 11th Edition. This manual is available from the Idaho Dietetic Association, online at http://eatrightidaho.org. (2-22-18)T

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (2-22-18)T

02. Mailing Address. (2-22-18)T

a. The mailing address of the Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (2-22-18)T

b. The mailing address of the Department's Division of Licensing and Certification, P.O. Box 83720, Boise, Idaho 83720-0009. (2-22-18)T

03. Street Address. (2-22-18)T

a. The street address of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (2-22-18)T

b. The street address of the Department's Division of Licensing and Certification is located at 3232 Elder Street, Boise, Idaho 83705. (2-22-18)T

04. Telephone. (2-22-18)T

a. The telephone number of the Idaho Department of Health and Welfare is (208) 334-5500. (2-22-18)T

b. The telephone number of the Department's Division of Licensing and Certification is (208) 334-1959. (2-22-18)T

05. Internet Websites. (2-22-18)T

a. The Department internet website is found at http://www.healthandwelfare.idaho.gov. (2-22-18)T

b. The Department's Division of Licensing and Certification internet website is found at http://lc.dhw.idaho.gov. (2-22-18)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law, and must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (2-22-18)T

02. Public Records Act. The Department will comply with Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (2-22-18)T

03. Disclosure of a Person's Identity. According to Section 39-1310, Idaho Code, information received by the Department's Division of Licensing and Certification through filed reports, inspections, or as required by law, will not be disclosed publicly in such a manner as to identify persons except as necessary in a proceeding involving a question of licensure. (2-22-18)T

04. Public Availability of Survey Reports. The Department's Division of Licensing and Certification will post on its website, survey reports and findings of complaint investigations relating to the facility at http://lc.dhw.idaho.gov. (2-22-18)T

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Administrators, employees, consultants, and contractors for the facility must have a criminal history and background check clearance as provided in IDAPA 16.05.06, "Criminal History and Background Checks." (2-22-18)T

010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH K.
For the purposes of this chapter of rules, the following terms apply. (2-22-18)T

01. Abuse. The infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish. Specifics are as follows: (2-22-18)T

a. Physical abuse is any action which causes physical harm or pain, trauma, or bodily harm such as hitting, slapping, punching, kicking, and pinching. It includes the use of excessive force or improper technique when placing a person in restraints, the use of restraints which are not specified in the facility's policies and procedures or ordered by the physician and consented to by the legal guardian in the person's Individual Treatment Plan (ITP) and restraint of any form imposed as a means of coercion, punishment, convenience, or retaliation by staff. All injuries sustained by the person during restraint or injuries suspected to be sustained during restraint must be investigated for potential abuse. (2-22-18)T

b. Psychological abuse is any action, situation or circumstance that is detrimental to the person's psychological well-being including humiliation, harassment, and threats of punishment or deprivation, sexual coercion and intimidation. People residing in the facility may be unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically abusive by the general public, would also be viewed as abusive by the person residing in the facility, regardless of that person's perceived ability to comprehend the nature of the incident. (2-22-18)T

c. Sexual abuse is rape, sexual assault, or any incident where a person is coerced, manipulated or otherwise enticed by another individual to engage in any form of sexual activity. (2-22-18)T

d. Verbal abuse is any use of insulting, demeaning, disrespectful, oral, written or gestured language

directed towards and in the presence of a person. People residing in the facility may be unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as verbally abusive by the general public, would also be viewed as abusive by the person residing in the facility, regardless of that person's perceived ability to comprehend the nature of the incident. (2-22-18)T

e. Punishment is modifying a person's diet, or withholding food, or hydration, medical care or treatment, or the use of restrictive interventions, including physical restraint and chemical restraints as a means to discipline or penalize a person. (2-22-18)T

02. **Administrator**. The individual delegated the responsibility for management of the facility. (2-22-18)T

03. **Advocate**. A individual who assists the person in exercising his rights within the facility and as a citizen of the United States. An advocate cannot make legal or other decisions on behalf of the person. The role of the advocate is limited to assisting the person only. (2-22-18)T

04. **Behavioral Management Needs**. Behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities. (2-22-18)T

05. **Board**. The Idaho State Board of Health and Welfare. (2-22-18)T

06. **Chemical Restraint**. A drug or medication when it is used as a restriction to manage the person's behavior or restrict the person's freedom of movement and it not a standard treatment or dosage for the person's condition. (2-22-18)T

07. **Clinical Case Manager**. The professional staff person responsible for the assessment, implementation, coordination, integration, and monitoring of each person's treatment program. The clinical case manager must hold a master's degree in a human service related field and have a minimum of one (1) year of experience working with people who have an intellectual disability, a serious chronic mental illness, or both. (2-22-18)T

08. **Deficient Practice**. The facility's failure to meet an individual requirement stated in these rules. (2-22-18)T

09. **Department**. The Idaho Department of Health and Welfare. (2-22-18)T

10. **Developmental Disability**. A developmental disability as defined in Section 66-402, Idaho Code, or an intellectual disability as defined in Section 73-114, Idaho Code. (2-22-18)T

11. **Director**. The Director of the Idaho Department of Health and Welfare, or his designee. (2-22-18)T

12. **Discharge**. The permanent movement of a person to another facility or setting that is physically separate and distinct from the secure treatment facility. (2-22-18)T

13. **Facility**. See "Secure Treatment Facility" in these rule definitions. (2-22-18)T

14. **Facility Administration**. The individual or individuals identified by the Director to manage the secure treatment facility. (2-22-18)T

15. **Forced Compliance**. The act of physically forcing a person to complete a task or activity. (2-22-18)T

16. **Grievance**. A formal or informal written or verbal complaint that is made to the facility by a person, or the person's representative, regarding the person's care. This does not include complaints that are resolved at the time of the complaint by staff present, allegations of abuse, neglect or mistreatment, or appeals. (2-22-18)T

17. **Immediate Jeopardy**. A situation in which the facility's noncompliance with one or more of the requirements of licensure has caused, or is likely to cause serious injury, harm, impairment, or death to a person. (2-22-18)T

18. **Independent Living Skills**. Skills essential to independent living that include bathing, dressing, food shopping, meal preparation, housekeeping and kitchen chores, laundry, bed making, and budgeting. (2-22-18)T

19. **Individual Treatment Plan (ITP)**. A written plan developed by the interdisciplinary team for each person in the facility which is consistent with trauma-informed care and person-centered care principles. The ITP is based on a complete, thorough assessment of the person. The ITP must include program strategies that are effective in ameliorating the behaviors that resulted in the person's admission to the secure treatment facility, the teaching of self-management strategies to promote discharge to a less restrictive living environment, and prevent or decelerate the regression or loss of optimal functional status. Each person's ITP addresses what a person needs in order to function with as much independence as possible by stating the following: (2-22-18)T

a. The desired outcomes the person is trying to achieve; (2-22-18)T

b. The specific steps and actions that will be taken to reach the desired outcomes; and (2-22-18)T

c. Any additional adaptive equipment, assistive technology, services, and supports required to meet the person's needs. (2-22-18)T

20. **Interdisciplinary Team (IDT)**. Professionals, paraprofessionals, and nonprofessionals who possess the knowledge, skills, and expertise necessary to accurately assess and identify the function of the behavior(s) that resulted in a person's admission to the facility and design a program that includes strategies that are effective in ameliorating those behaviors and teaching self-management strategies to promote discharge to a less restrictive living environment. The IDT must include the person, unless inability or unwillingness is documented, the person's legal guardian, and any other individual the person wishes to be present, including advocates and family members unless documented to be inappropriate or unobtainable, a physician, a social worker, and other appropriate professional and nonprofessional staff, at least one (1) of whom is a clinical case manager. (2-22-18)T

21. **Isolation.** See "Seclusion" in these rule definitions. (2-22-18)T

011. DEFINITIONS AND ABBREVIATIONS -- L THROUGH Z.
For the purposes of this chapter of rules, the following terms apply. (2-22-18)T

01. **Legal Guardian**. An individual appointed by the court in accordance with Section 15-5-301, Idaho Code, or Section 66-404, Idaho Code. The guardian's role is to act in the person's best interest, encourage self-reliance and independence, as well as make decisions on behalf of the person. (2-22-18)T

02. **Licensing and Certification**. The Department's Division that is responsible for the licensing and surveying activities of the facility. (2-22-18)T

03. **Mistreatment**. Behavior or facility practices that result in any type of person exploitation such as financial, physical, sexual, or criminal exploitation. Mistreatment also refers to the use of behavioral management techniques outside of their use as specified in the facility policies and procedures or ordered by the physician and consented to by the legal guardian in the person's Individual Treatment Plan (ITP). (2-22-18)T

04. **National Association for Persons with Developmental Disabilities and Mental Health Needs (NADD)**. NADD is a not-for-profit membership association established for professionals, care providers and families to promote understanding of and services for individuals who have developmental disabilities and mental health needs. NADD offers information and multiple resources regarding trauma-informed care principles, reduction and elimination of restraint and seclusion, person-centered care and other related topics which are available online at http://thenadd.org. (2-22-18)T

05. **Neglect**. The failure to provide goods or services necessary to avoid physical harm, mental anguish

or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior will constitute neglect. Staff failure to implement safeguards, once person to person aggression is identified, will also constitute neglect. (2-22-18)T

06. **Noxious Stimuli**. A startling, unpleasant, or painful action used in response to a person's behavior that has a potentially aversive or harmful effect. (2-22-18)T

07. **Person**. An individual subject to judicial proceedings, authorized by the provisions of Title 66, Chapter 14, Idaho Code, who is being considered for disposition or is admitted and dispositioned into the secure treatment facility. (2-22-18)T

08. **Person-Centered Care**. To focus on the person as the locus of control and to support the person in making his own choices and having control over his daily life. (2-22-18)T

09. **Physical restraint**. Any manual hold or mechanical device, material or equipment that the person cannot remove easily, and that restricts the free movement of, normal functioning of, or normal access to a portion or portions of a person's body. (2-22-18)T

10. **Physician**. An individual licensed to practice medicine and surgery by the Idaho State Board of Medicine or the Idaho State Board of Podiatry according to Section 39-1301(h), Idaho Code. (2-22-18)T

11. **PRN**. "Pro Re Nata" meaning "as needed." (2-22-18)T

12. **Provisional License**. A license issued to a facility that conforms substantially to these rules, during which time the facility implements administrative or major structural changes. (2-22-18)T

13. **Reportable Incident**. A situation when a facility is required to report information to the Department's Division of Licensing and Certification that includes the following: (2-22-18)T

a. An injury must be reported as an "injury of unknown source" when the following occurs: (2-22-18)T

i. The source of the injury was not witnessed by anyone and the source of the injury could not be explained by the person; and (2-22-18)T

ii. The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the number of injuries observed over time. (2-22-18)T

b. Elopement is when a person physically leaves the facility premises without the facility's knowledge. (2-22-18)T

c. Person to person physical altercations with or without injury. (2-22-18)T

d. An incident that results in the person's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Reporting of these incidents must include documentation of when the person was last subjected to physical and chemical restraint. (2-22-18)T

e. All allegations of staff abuse, neglect, and mistreatment. (2-22-18)T

14. **Restrictive Intervention**. An intervention that is used to restrict the rights or freedom of movement of a person. (2-22-18)T

15. **Seclusion**. The involuntary isolation and confinement of a person in a locked room or area. (2-22-18)T

16. **Secure Treatment Facility**. The facility to be operated by the Department to fulfill the purposes of

this chapter. A secure treatment facility will be referred to as "facility" in these rules. The facility will include: (2-22-18)T

a. Locked, fenced, and enclosed grounds accessible only to persons, staff, and authorized individuals; (2-22-18)T

b. Locked residential units; (2-22-18)T

c. Bedroom and building exit alarms; (2-22-18)T

d. Monitoring cameras in all common areas; (2-22-18)T

e. Modified interiors to reduce risk of suicide; and (2-22-18)T

f. Restricted access to items that could be used as weapons. (2-22-18)T

17. **Serious injury.** Any significant impairment of the physical condition of the person as determined by qualified medical personnel. This includes burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. (2-22-18)T

18. **Serious Mental Illness.** Any of the following psychiatric illnesses as defined by the American Psychiatric Association in the diagnostic and statistical manual of mental disorders: (2-22-18)T

a. Schizophrenia spectrum and other related disorders; (2-22-18)T

b. Paranoia and other psychotic disorders; (2-22-18)T

c. Bipolar and other related disorders; (2-22-18)T

d. Depressive disorders; (2-22-18)T

e. Trauma and stressor-related disorders; (2-22-18)T

f. Anxiety disorders; (2-22-18)T

g. Obsessive-compulsive and other related disorders; (2-22-18)T

h. Dissociative disorders; and (2-22-18)T

i. Personality disorders. (2-22-18)T

19. **Substance Abuse and Mental Health Administration (SAMHSA).** SAMHSA is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA offers information and multiple resources regarding trauma-informed care principles, the reduction and elimination of restraint and seclusion, person-centered care, and other related topics that are available online at https://www.samhsa.gov. (2-22-18)T

20. **Substantial Compliance.** The facility is in substantial compliance with these rules when all Standards of Licensure are met. (2-22-18)T

21. **Substantial Threat to the Safety of Others.** The presentation, by a person, of a substantial risk to physically harm other persons, as manifested by evidence of violent behavior. (2-22-18)T

22. **Sufficient Staff.** Enough on duty, trained personnel to effectively implement the treatment programs as defined in the Individual Treatment Plan (ITP), to meet each person's needs, and to respond to emergencies, illness, or injuries on a twenty-four (24) hour basis. (2-22-18)T

23. **Time-Out.** Reducing or limiting the amount of reinforcement that is available to a person for a period of time, either by removing a person from his environment (exclusionary) or changing the existing environment (inclusionary). (2-22-18)T

24. **Time-Out Room.** A specific room used in exclusionary time-out procedures from which egress is prevented. (2-22-18)T

25. **Transfer.** A transfer means the following: (2-22-18)T

a. The temporary movement of a person from the facility to a psychiatric or medical hospital for medical reasons; (2-22-18)T

b. The permanent movement of an entire facility to a new location, including people served, staff, and records. (2-22-18)T

26. **Trauma-Informed Care.** Under the Substance Abuse and Mental Health Administration (SAMHSA), trauma-informed care is a system of care that incorporates key trauma principles into the facility's culture and each person's treatment interventions and supports. Key trauma principles include: (2-22-18)T

a. Safety. The facility staff and persons feel physically and psychologically safe based on the physical environment and interpersonal interactions that promote a sense of safety. (2-22-18)T

b. Trustworthiness and Transparency. The facility's operations and decisions are conducted with transparency with the goal of building and maintaining trust among persons, guardians, advocates, staff, and all other individuals involved with the facility. (2-22-18)T

c. Peer Support. Peer support and mutual self-help are utilized to build safety, hope, and trust and to enhance collaboration. Shared stories and life experiences are utilized to promote recovery and healing. (2-22-18)T

d. Collaboration and Mutuality. All facility staff actively work to reduce the power differences between staff and persons to the maximum extent possible through the meaningful sharing of power and decision-making. (2-22-18)T

e. Empowerment, Voice, and Choice. The facility's operations and staff training programs are organized to ensure the safety and empowerment of both persons and staff. Individual strengths and experiences are recognized and built upon, and shared decision-making, choices, and goal-setting is supported. Each staff's role as a facilitator rather than a controller is recognized and promoted. (2-22-18)T

f. Cultural, Historical, and Gender Issues. The facility's operations are responsive to gender and the racial, ethnic, and cultural needs of each person, and recognize and address each person's historical trauma. (2-22-18)T

27. **Treatment.** The implementation of a professionally developed and supervised Individual Treatment Plan (ITP) designed to achieve the person's discharge from the facility at the earliest possible time. Treatment requires the person to be actively involved in the development and implementation of his own treatment plan with the support of his legal guardian, advocate, family members, friends, professional, paraprofessional, and non-professional facility staff. (2-22-18)T

28. **Unremoved Immediate Jeopardy.** An immediate jeopardy situation that the facility could not resolve by the time of the survey exit conference. (2-22-18)T

012. -- 019. (RESERVED)

020. LICENSURE - GENERAL REQUIREMENTS.

01. **License Requirement.** The facility for persons with intellectual disabilities cannot be established, maintained, or operated within Idaho without obtaining a license from the Department's Division of Licensing and

Certification as required in Section 66-1402, Idaho Code. Only one (1) facility in Idaho can be licensed as a secure treatment facility for people with intellectual disabilities. The facility must be in compliance with applicable federal, state, and local laws, regulations, codes, and this chapter of rules in order to hold a license. (2-22-18)T

02. **Facility Name**. The facility must use a distinctive name. The facility cannot change its name without written notification to the Department's Division of Licensing and Certification at least thirty (30) calendar days prior to the date the proposed name change is to be effective. (2-22-18)T

03. **Physical Location**. The facility must meet the requirements according to Sections 67-6530 through 67-6532, Idaho Code, for local planning and zoning laws or ordinances. (2-22-18)T

04. **Size Limitation.** The maximum size of this facility must be no more than four (4) beds. (2-22-18)T

05. **Compliance with Water and Sanitation Rules**. This facility must have a statement from the Public Health District indicating that the municipal water supply and sewage disposal systems meet the requirements in Section 004 of these rules. (2-22-18)T

06. **Approval of Facility Construction Plans.** This facility must obtain written approval from the Department's Division of Licensing and Certification prior to any proposed construction of a facility or alterations to the facility. Construction or alteration plans must be provided prior to licensing of the facility and must meet Sections 830 through 844 of these rules. (2-22-18)T

021. -- 024. (RESERVED)

025. INITIAL APPLICATION FOR LICENSURE.
The facility must apply to the Department's Division of Licensing and Certification for an initial license to operate the facility. (2-22-18)T

01. **Form of Application**. The applicant must complete an initial application form provided by the Department's Division of Licensing and Certification. The application and documents required in Subsection 025.02 of this rule must be submitted to the Division of Licensing and Certification at least ninety (90) calendar days prior to the planned opening date. (2-22-18)T

02. **Documents Required**. In addition to the application form, the following documents must be submitted with the application prior to approval of a license: (2-22-18)T

a. A certificate of occupancy from the local building and fire authority; (2-22-18)T

b. Fire alarm record of completion; (2-22-18)T

c. Sprinkler contractors material and test certificate for aboveground piping; (2-22-18)T

d. Installers letter of code compliance for fuel fired appliances; (2-22-18)T

e. Acceptable policies and procedures governing the facility; and (2-22-18)T

f. A sample of a person's record. (2-22-18)T

026. -- 029. (RESERVED)

030. ISSUANCE OF LICENSE.
The facility license is issued when the Department's Division of Licensing and Certification finds that the applicant has demonstrated compliance with the requirements in Idaho statutes and these rules. (2-22-18)T

01. **Initial License**. When the Department's Division of Licensing and Certification determines that all required application information has been received and demonstrates compliance, a license is issued. The initial license expires at the end of the calendar year in which the license was issued. (2-22-18)T

02. **License Issued Only to Named Applicant and Location.** The license is issued only for the facility named and location stated in the application. (2-22-18)T

03. **License Specifies Maximum Allowable Beds.** The license specifies the maximum allowable number of beds in the facility. (2-22-18)T

04. **Provisional License.** A provisional license is valid for a period not to exceed six (6) months from the date of issuance by the Department's Division of Licensing and Certification. A provisional license may be issued to the facility for the following reasons: (2-22-18)T

a. Implement administrative changes; or (2-22-18)T

b. Implement structural changes to a facility's premises. (2-22-18)T

031. EXPIRATION AND RENEWAL OF LICENSE.
The facility license issued by the Department's Division of Licensing and Certification is valid until the end of the calendar year in which it is issued. The license is renewed annually unless the license is revoked or suspended. (2-22-18)T

032. LICENSE AVAILABLE.
The facility must have its license on the premises and available upon request. (2-22-18)T

033. -- 039. (RESERVED)

040. INSPECTION OF FACILITY.

01. **Representatives of the Department's Division Licensing and Certification.** The Department's Division of Licensing and Certification is authorized to enter this facility, or its buildings associated with its operation, at all times for the purpose of inspection surveys. The Department's Division of Licensing and Certification may, at its discretion, utilize the services of any legally qualified person or organization, either public or private, to examine and inspect the facility for licensure requirements. (2-22-18)T

02. **Accessible With or Without Prior Notification.** Inspection surveys are made unannounced and without prior notice at the discretion of the Department's Division of Licensing and Certification. (2-22-18)T

03. **Inspection of Records.** For the purposes of these rules, the Department's Division of Licensing and Certification is authorized to inspect all paper, electronic, video, and audio records pertinent to person care as required to be maintained by the facility. (2-22-18)T

04. **Interview Authority.** A surveyor has the authority to interview any individual associated with the facility or the provision of care including the license holder, administrator, staff, people residing at the facility, their family members and advocates, service providers, physicians, or other legally responsible individuals. Interviews are confidential and conducted privately unless otherwise specified by the interviewee. (2-22-18)T

05. **Inspection of Outside Services.** The Department's Division of Licensing and Certification is authorized to inspect any outside services that a licensed facility uses for the people residing at the facility.(2-22-18)T

041. LICENSURE SURVEYS.

01. **Surveys of Facilities.** The Department's Division of Licensing and Certification will ensure that surveys are conducted at specified intervals in order to determine compliance with this chapter and applicable rules and statutes. The intervals of surveys will be as follows: (2-22-18)T

a. An initial survey is conducted within sixty (60) calendar days from initial licensure. The initial survey may be delayed until a person has been admitted and is present at the facility. (2-22-18)T

b. A relicensure survey is conducted on average once per year, or more frequently at the discretion of the Department's Division of Licensing and Certification. A relicensure survey may be delayed until a person has been admitted and is present at the facility. (2-22-18)T

c. A complaint investigation survey is conducted based on the severity of an alleged violation of these rules or statutes, or any reportable incident that indicates there was a violation of the rules or statute. (2-22-18)T

i. A complaint alleging immediate jeopardy to a person is conducted within one (1) business day. (2-22-18)T

ii. A complaint not alleging immediate jeopardy to a person is conducted within five (5) calendar days. (2-22-18)T

02. Follow-up Surveys. Follow-up surveys may be conducted at the discretion of the Department's Division of Licensing and Certification to ascertain corrections to noncompliance with these rules. Follow-up surveys are conducted per time frames established in the facility's acceptable plan of correction, but must not exceed the following: (2-22-18)T

a. Offsite follow-up surveys may be conducted at the discretion of the Department's Division of Licensing and Certification to ascertain corrections to deficiencies within ninety (90) calendar days of the facility's alleged compliance date. (2-22-18)T

b. Onsite follow-up surveys may be conducted by the Department's Division of Licensing and Certification to ascertain corrections to deficiencies that do not include an unremoved immediate jeopardy to health and safety within a period of ninety (90) calendar days from the originating survey exit date. If an onsite follow-up is conducted, and it is not verified by the Department's Division of Licensing and Certification that the facility is in substantial compliance by the end of the 90-day period, then the facility's license will be revoked. (2-22-18)T

i. The Department's Division of Licensing and Certification will conduct onsite follow-up surveys to ascertain corrections to deficiencies that include an unremoved immediate jeopardy to health and safety within thirty (30) calendar days after the receipt of the Statement of Deficiencies and Plan of Correction form if cited deficiencies include an immediate jeopardy to health and safety that was not removed prior to the survey exit date. (2-22-18)T

ii. Expedited revocation will occur in no less than five (5) calendar days and no more than thirty (30) calendar days after the receipt of the Statement of Deficiencies and Plan of Correction form. Specific time frames will be determined by the Department's Division of Licensing and Certification on a case-by-case basis and provided to the facility in writing. (2-22-18)T

iii. The facility may request that an onsite follow-up be conducted immediately upon receipt of the written notice by submitting an acceptable plan of correction alleging that the immediate jeopardy has been removed. If an onsite follow-up is conducted, and it is verified that the immediate jeopardy has been removed, then expedited revocation action will convert to a 90-day revocation action. (2-22-18)T

042. -- 049. (RESERVED)

050. COMPLAINTS.

01. Filing a Complaint. Any individual who believes that the facility has failed to meet any provision of the rules or statute may file a complaint with the Department's Division of Licensing and Certification. All complaints must have a basis in rule or statutory requirements. If it does not, the complainant will be referred to the appropriate entity or agency. (2-22-18)T

02. Disclosure of Complaint Information. The Department's Division of Licensing and Certification will not disclose the name or identifying characteristics of a complainant unless one of the following events occurs: (2-22-18)T

a. The complainant consents in writing to the disclosure; (2-22-18)T

b. The investigation results in a judicial proceeding, and disclosure is ordered by the court; or (2-22-18)T

c. The disclosure is essential to prosecution of a violation. The complainant is given the opportunity to withdraw the complaint before disclosure. (2-22-18)T

03. **Notification to Complainant**. The Department's Division of Licensing and Certification will inform the complainant of the results of the investigation survey when the complainant has provided a name and address. (2-22-18)T

051. -- 059. (RESERVED)

060. WRITTEN REPORT OF DEFICIENCIES.
The Department's Division of Licensing and Certification will provide a written Statement of Deficiencies and Plan of Correction form to the facility to support any deficiencies found. (2-22-18)T

01. **Written Reports with Removed Immediate Jeopardy**. Written reports of deficiencies, including immediate jeopardy to health and safety that was removed prior to the survey exit date, will be provided within ten (10) business days from the survey exit date. (2-22-18)T

02. **Written Reports with Unremoved Immediate Jeopardy**. Written Reports of deficiencies that include immediate jeopardy to health and safety that was not removed prior to the survey exit date will be provided within two (2) business days from the survey exit date. (2-22-18)T

061. -- 069. (RESERVED)

070. ENFORCEMENT PROCESS.
The Department's Division of Licensing and Certification may impose a remedy or remedies when it determines the facility is not in compliance with these rules. (2-22-18)T

01. **Determination of Remedy**. In determining which remedy or remedies to impose, the Department's Division of Licensing and Certification will consider the facility's compliance history, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to persons. Subject to these considerations, any of the remedies in Sections 071 through 073 of these rules may be imposed, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal. Written notification of all remedies imposed will be provided to the facility with the Statement of Deficiencies and Plan of Correction form. (2-22-18)T

02. **Enforcement Remedies**. When the Department's Division of Licensing and Certification determines that the facility is out of compliance with these rules, it may impose any of the following remedies: (2-22-18)T

a. Require the facility to submit an acceptable plan of correction that must be approved by the Department's Division of Licensing and Certification; (2-22-18)T

b. Revoke the facility's license; (2-22-18)T

c. Issue a summary suspension of the facility's license. (2-22-18)T

071. PLAN OF CORRECTION.
An acceptable plan of correction must be developed and returned to the Department's Division of Licensing and Certification for all deficiencies within ten (10) calendar days of receipt of the Statement of Deficiencies and Plan of Correction form. An acceptable plan of correction must include the following: (2-22-18)T

01. **Correcting Deficient Practice**. How the corrective action will be accomplished for each person found to have been affected by the deficient practice; (2-22-18)T

02. **Identify Potentially Affected Persons**. How the facility will identify other people who have the potential to be affected by the same deficient practice, and how the facility will act to protect those people in similar situations; (2-22-18)T

03. **Changes to Prevent Recurrence**. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; (2-22-18)T

04. **Monitoring Corrective Actions and Performance**. How the facility will monitor its corrective actions and performance to ensure that the deficient practice is being corrected and will not recur, including what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; (2-22-18)T

05. **Target Date of Corrective Action Completion**. The date when corrective action must be accomplished. Except in unusual circumstances, and only with the approval of the Department's Division of Licensing and Certification, no correction date will be more than ninety (90) calendar days from the inspection exit date as printed on the Statement of Deficiencies and Plan of Correction form; and (2-22-18)T

06. **Administrator's Signature and Date Submission**. The administrator's signature and the date submitted. (2-22-18)T

072. **DENIAL OR REVOCATION OF LICENSE.**
The Department's Division of Licensing and Certification may deny an application for a license or revoke an existing license when the facility's noncompliance with the requirements in this chapter of rules lead to a substantial risk to the health and safety of a person. (2-22-18)T

01. **Notice to Deny or Revoke**. The Department's Division of Licensing and Certification will send a written notice to the facility by certified mail, registered mail, or personal delivery service, to deny an application for a license or revoke an existing license. The notice will inform the facility of the opportunity to request a hearing as provided in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (2-22-18)T

02. **Repeated Noncompliance**. The Department's Division of Licensing and Certification may revoke an existing license for the repeated violations of any requirements in Idaho Code or these rules. (2-22-18)T

03. **Accumulation of Citations for Noncompliance**. The Department's Division of Licensing and Certification may revoke an existing license for the accumulation of citations for noncompliance at the facility that, taken as whole, would endanger the health, safety, or welfare of a person. (2-22-18)T

04. **Personnel Inadequacies**. The Department's Division of Licensing and Certification may deny an application for a license or revoke an existing license when the facility lacks sufficient staff in number or qualification to properly care for the proposed or actual number of people residing at the facility. (2-22-18)T

05. **Inadequate or False Disclosure**. The Department's Division of Licensing and Certification may deny an application for a license or revoke an existing license when the administrator has misrepresented, or failed to fully disclose, any facts or information or any items in any application or any other document requested by the Department's Division of Licensing and Certification, when such facts and information were required to have been disclosed. (2-22-18)T

073. **SUMMARY SUSPENSION OF A LICENSE.**
The Director may summarily suspend the facility license in the event of any emergency endangering the health, safety, or welfare of a person in the facility. At the time of suspension, the Director will redisposition each person residing at the facility. The Director will provide an opportunity for a contested case hearing according to IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (2-22-18)T

074. -- 079. **(RESERVED)**

080. **RETURN OF SUSPENDED, REVOKED, OR RELINQUISHED LICENSE.**
The facility license is the property of the State of Idaho and must be returned to the Department's Division of

Licensing and Certification immediately upon its suspension, revocation, or the voluntary closure of the facility. (2-22-18)T

081. -- 089. (RESERVED)

090. WAIVER.
According to Section 39-1306, Idaho Code, a temporary waiver to these rules and minimum standards, either in whole or in part, may be granted by the Department's Division of Licensing and Certification to the facility for a period not to exceed one (1) year. Waivers are granted on a case-by-case basis according to the following conditions: (2-22-18)T

01. **Waiver for Good Cause.** The Department's Division of Licensing and Certification finds good cause to grant a waiver and no person's health, safety, or welfare is endangered by the waiver being granted. (2-22-18)T

02. **No Precedent.** Precedent will not be set by granting the requested waiver, and such waiver will have no force or effect in any other proceeding. (2-22-18)T

091. -- 099. (RESERVED)

100. STANDARD OF LICENSURE: FACILITY ADMINISTRATION.
The Director must identify an individual or individuals to manage the facility. To the degree possible, considering the limitations in the facility, the facility's administration is responsible to ensure the facility's culture is consistent with trauma-informed care principles and person-centered care principles through policy development, implementation, quality assurance monitoring, and physical environment organization. The facility's training and development must be ongoing and must include person-centered, evidence-based trauma specific screening, assessment and interventions necessary to develop and sustain a culture that promotes the engagement, involvement, and collaboration of the person, the person's legal guardian, the person's family members, the person's advocate, all professional, paraprofessional, and direct care staff, and all other interested parties, including the facility's Human Rights Committee. (2-22-18)T

01. **Necessary Staffing, Training Resources, Equipment and Environment.** The individuals charged with managing the facility must develop, monitor, and revise, as necessary, policies and operating directions that ensure the necessary staffing, training resources, equipment, and environment to provide each person with comprehensive treatment, and to provide for his health and safety consistent with trauma-informed care principles and person-centered care principles; (2-22-18)T

02. **Health, Safety, Sanitation, Maintenance and Repair.** Facility administration must exercise general policy, budget, and operating direction over the facility, and include areas such as health, safety, sanitation, maintenance and repair, utilization and management of staff, and maintenance and oversight of the facility's quality assessment performance improvement program; and (2-22-18)T

03. **Federal, State and Local Laws, Regulations and Codes.** Facility administration must maintain compliance with all applicable federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation. (2-22-18)T

101. SERVICES PROVIDED UNDER AGREEMENTS WITH OUTSIDE SOURCES.
If the facility does not directly provide a service, facility administration must have a written agreement with an outside program, resource, or service provider to furnish the necessary service. The agreement must contain the responsibilities, functions, objectives, and other terms agreed to by both parties and meet the needs of each person. (2-22-18)T

102. GRIEVANCE PROCESS.
Facility administration must develop, implement, and monitor policies and procedures for the prompt resolution of each person's grievances according to Subsection 304.08 of these rules. The facility must inform each person, each person's legal guardian, and the person's advocate whom to contact to file a grievance under Subsection 302.01 of these rules. (2-22-18)T

103. ABUSE, NEGLECT, AND MISTREATMENT PREVENTION, DETECTION, INVESTIGATION, AND RESOLUTION PROCESS.
Facility administration must develop, implement, and monitor policies and procedures for the prevention, detection, investigation, and resolution of abuse, neglect, mistreatment, and suspicious injuries of unknown source according to Subsection 304.02 of these rules. The facility must inform each person, the person's legal guardian, the person's advocate, and whom to contact to file an allegation of abuse, neglect, mistreatment, and report a suspicious injury of unknown source according to Subsection 302.01 of these rules. (2-22-18)T

104. -- 109. (RESERVED)

110. ADMINISTRATOR.
The administration of the facility must appoint an administrator that meets the requirements and is responsible for the duties in this Section of rule. (2-22-18)T

01. Administrator Requirements. The facility must have an administrator who meets the following requirements: (2-22-18)T

a. Is at least twenty-one (21) years of age; (2-22-18)T

b. Has a minimum three (3) years direct experience working with people with intellectual or developmental disabilities, or mental illness, or both; and (2-22-18)T

c. Meets all other qualifications required by the facility administration. (2-22-18)T

02. Administrator Duties. The administrator's responsibilities and duties are to perform the following: (2-22-18)T

a. Implement and monitor written policies and procedures for the facility, and the operation of its physical plant. The administrator is the responsible and accountable for implementation of the policies established by facility administration. The administrator must see that these policies and procedures are adhered to, and must make them available to authorized representatives of the Department's Division of Licensing and Certification. (2-22-18)T

b. Notify the Department's Division of Licensing and Certification of an anticipated or actual termination of any service vital to the continued safe operation of the facility or the health, safety, and welfare of its persons and personnel within one (1) business day. (2-22-18)T

c. Notify the Department's Division of Licensing and Certification, in writing, of all reportable incidents within one (1) business day of the incident's occurrence. (2-22-18)T

d. Notify the Department's Division of Licensing and Certification when the facility census changes from zero (0) to one (1) or from one (1) to zero (0). (2-22-18)T

e. When not on duty, delegate the necessary authority to an administrator designee who is competent to handle the administrator's duties. Delegation of authority must occur according to the facility policies and procedures set by the facility administration. In the event of an emergency, the administrator designee must know how to contact the administrator. (2-22-18)T

111. -- 119. (RESERVED)

120. FACILITY RECORDS.

01. Records Available Upon Request. The facility must be able to print and provide paper copies of electronic records upon the request of the person who is the subject of the requested records, the person's legal guardian, payer, or the Department's Division of Licensing and Certification. (2-22-18)T

02. Census Register. The facility must maintain a census register that lists the following: (2-22-18)T

a. Full name, age, sex, and diagnoses of each person admitted to the facility; (2-22-18)T

b. The person's date of admission and discharge; and (2-22-18)T

c. A daily census of each person who is in the facility on any given day. (2-22-18)T

121. RECORDS REQUIREMENTS.

01. Separate Record. The facility must develop and maintain a record keeping system that includes a separate record for each person and that accurately documents comprehensive information related to the person's health care, treatment, social information, and protection of the person's rights. (2-22-18)T

02. Confidentiality. The facility must keep confidential all information contained in each person's records, regardless of the form or storage method of the records. (2-22-18)T

03. Release of Information. The facility must develop and implement policies and procedures governing the release of any person's information. The policy must include obtaining written informed consent from the person or the person's legal guardian prior to information being released. (2-22-18)T

04. Record Entries. Any individual who makes an entry in a person's record must make it legibly, date it, sign it, and include his position. (2-22-18)T

05. Legend. The facility must provide a legend, developed and maintained by facility administration, to explain any symbol or abbreviation used in a person's record. (2-22-18)T

06. Access by Staff. The facility must provide facility staff with appropriate aspects of each person's record. (2-22-18)T

122. -- 129. (RESERVED)

130. FINANCES.

01. Established Financial System. The facility must establish and maintain a system to manage all personal funds entrusted to the facility on behalf of each person. The system must do the following: (2-22-18)T

a. Ensure a full and complete accounting of funds; (2-22-18)T

b. Preclude any commingling of a person's funds with facility funds or with the funds of any other individual; and (2-22-18)T

c. Ensure each person is not placed at risk of benefit loss. (2-22-18)T

02. Available upon request. The person's financial record must be available on request of the person, and the person's legal guardian or advocate. (2-22-18)T

131. -- 199. (RESERVED)

200. STANDARD OF LICENSURE: FACILITY STAFFING.
The facility must provide sufficient numbers of qualified, trained, competent professional, paraprofessional, non-professional, technical, and consultative personnel to meet each person's needs. (2-22-18)T

201. SUFFICIENT PERSONNEL.
The facility must employ personnel sufficient in number and qualifications to meet the needs of each person residing at the facility. While minimum direct care staff ratios are defined in Subsection 201.01 of this rule, a person's treatment and services may require more staff than the minimum. The facility must provide sufficient numbers of staff to manage and supervise persons in accordance with their Individual Treatment Plans (ITP). (2-22-18)T

01. Minimum Direct Care Staff. The use of volunteers and students in the facility is not allowed. Minimum ratios of staff to persons must be maintained as follows: (2-22-18)T

a. When the total count of persons in the facility is one (1), a minimum of two (2) staff must be awake, on-duty, and available twenty-four (24) hours a day. (2-22-18)T

b. When the total count of persons in the facility is two (2), a minimum of three (3) staff must be awake, on-duty, and available during all person's waking hours. A minimum of two (2) staff must be awake, on-duty, and available during all person's sleeping hours. (2-22-18)T

c. When the total count of the persons in the facility is three (3), a minimum of four (4) staff must be awake, on-duty, and available during all person's waking hours. A minimum of two (2) staff must be awake, on-duty, and available during all person's sleeping hours. (2-22-18)T

d. When the total count of the persons in the facility is four (4), a minimum of five (5) staff must be awake, on-duty, and available during all person's waking hours. A minimum of three (3) staff must be awake, on-duty, and available during all person's sleeping hours. (2-22-18)T

02. Professional, Paraprofessional, Nonprofessional, Technical, and Consultative Personnel. The facility must employ adequate numbers of qualified professional, technical, and consultative personnel to be able to perform the following: (2-22-18)T

a. Evaluate each person; (2-22-18)T

b. Formulate written, individualized, comprehensive treatment plans; (2-22-18)T

c. Provide treatment measures; and (2-22-18)T

d. Engage in discharge planning. (2-22-18)T

202. FACILITY PERSONNEL DOCUMENTATION.
The facility must ensure that explicit and uniform policies and procedures are established for each employment position concerning hours of work, overtime, and related personnel matters. A statement of these policies must be provided to each employee. (2-22-18)T

01. Organizational Chart. A current organizational chart that clearly indicates lines of authority within the facility's organizational structure must be available at the facility to be viewed by all employees. (2-22-18)T

02. Job Descriptions. Current job descriptions outlining the authority, responsibilities, and duties of all personnel in the facility, including the administrator, must be established and maintained as required by facility administration. A copy of an employee's particular job description must be provided to each employee. (2-22-18)T

03. Daily Work Schedules. Daily work schedules must be maintained that show the personnel on duty at any given time for the previous three (3) month period. These schedules must be kept up to date and identify the employee as follows: (2-22-18)T

a. First and last names; (2-22-18)T

b. Professional designations such as licensed registered nurse (RN), licensed practical nurse (LPN), clinical case manager; and (2-22-18)T

c. Employment position in the facility. (2-22-18)T

203. PERSONNEL RECORDS.
A separate personnel record must be maintained for each employee of the facility that contains the following

information: (2-22-18)T

01. **The Employee's Name, Current Address, and Telephone Number.** (2-22-18)T

02. **The Employee's Social Security Number.** (2-22-18)T

03. **The Employee's Educational Background.** (2-22-18)T

04. **The Employee's Work Experience.** (2-22-18)T

05. **Other Employee Qualifications.** The employee's other qualifications to provide care. If licensure is required to provide a service the employee was hired to provide, the facility must document verification of the license number and date the current license expires; (2-22-18)T

06. **Criminal History Check.** The employee's criminal history and background check (CHC) clearance must be printed and on file, when a CHC is required; (2-22-18)T

07. **The Employee's Date of Employment.** (2-22-18)T

08. **Employee Date of Termination.** The employee's date of termination including the reason for termination; (2-22-18)T

09. **The Employee's Position in the Facility and a Description of that Position.** (2-22-18)T

10. **Employee Work Schedule.** The employee's hours and work schedule, paydays, overtime, and related personnel matters; and (2-22-18)T

11. **Training Plan.** Training and competency plan based on evaluation of the employee's performance. (2-22-18)T

12. **Documentation of All Allegations of Abuse, Neglect, and Mistreatment.** Staff personnel files must include documentation of all allegations of abuse, neglect, and mistreatment that have been made against the staff member, whether the allegation was substantiated or unsubstantiated, any corrective actions taken in response and the reasons why such actions were taken in accordance with IDAPA 15.04.01.190. (2-22-18)T

204. REQUIREMENTS OF PERSONNEL.

01. **Health and Age Requirements.** All personnel employed by the facility must meet and observe the following requirements: (2-22-18)T

a. Each employee must be free of communicable disease and open skin lesions while on duty; (2-22-18)T

b. At the time of employment, each employee must have a tuberculin skin test consistent with current tuberculosis control procedures; and (2-22-18)T

c. Each employee providing direct care to a person must be eighteen (18) years of age, or older. (2-22-18)T

02. **Training Requirements.** The facility must have and follow a structured, written training program designed to train each employee involved in each person's care in the responsibilities specified in the written job description, and to provide for quality of care, consistent with trauma-informed care, person-centered care principles, and compliance with these rules. Signed evidence of personnel training, indicating dates, hours, and topic, must be retained at the facility. The written training program must include information about how facility administration will ensure facility staff are able to demonstrate competence in applying the training to their job responsibilities. This training must include the following: (2-22-18)T

a. The facility must provide each employee with initial, continuing in-service training, and refresher training consistent with facility policy. Initial training must be provided prior to staff working directly with a person. At a minimum, refresher training must be provided annually. Training must enable the employee to perform his duties effectively, efficiently, and competently. Individuals providing staff training must be qualified as evidenced by documented education, training, and experience in the specific areas in which they are providing training. (2-22-18)T

b. Professional program staff must participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members. Documentation must include training related to trauma-specific screening and person-centered care principles, assessment, and interventions. (2-22-18)T

c. The facility must ensure all staff involved in a person's care must have ongoing education, training, and demonstrated knowledge to ensure each person's acute and chronic needs are met. Training must address the following: (2-22-18)T

i. Rights, including specific training on the facility's policies and procedures for the prevention and detection of abuse, neglect, and mistreatment; (2-22-18)T

ii. Treatment of health care needs, including basic first aid, CPR certification, and training on the use of the facility's emergency medical equipment; (2-22-18)T

iii. Treatment of developmental needs; (2-22-18)T

iv. Treatment of mental health needs; (2-22-18)T

v. Intervention strategies to address behavioral needs; (2-22-18)T

vi. Techniques to identify the behaviors, events, and environmental factors of each person and staff that may trigger emergency safety situations; (2-22-18)T

vii. The use of nonphysical intervention skills, such as de-escalation, mediation, conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; (2-22-18)T

viii. Specific training on the use of and risks associated with physical restraint use, including psychological effects, bruising, lacerations, fractures, serious impairment, and death caused by restraint compression asphyxia, strangulation, aspiration, blunt trauma to the chest, catecholamine rush, rhabdomyolysis, and thrombosis; (2-22-18)T

ix. Specific training prohibiting the use of seclusion, prone restraints, supine restraints, or other restraints that force a person against a hard surface, such as a wall, chair, or the floor due to increased psychological and physical risks to the person; (2-22-18)T

x. Specific training regarding the assistance with medications and the detection of adverse reactions to medications; (2-22-18)T

xi. Specific training regarding increased risk to each person's health and safety when chemical restraint is used concurrently with physical restraint; and (2-22-18)T

xii. Specific training on how to identify and respond to persons engaging in suicidal ideation or attempts. (2-22-18)T

xiii. Specific training on trauma-informed care principles, person-centered care, and methods to reduce and eliminate restraints that are consistent with Substance Abuse and Mental Health Services Administration (SAMHSA) guidance, National Association for Persons with Developmental Disabilities and Mental Health Needs (NADD) guidance, or other nationally recognized organizations. (2-22-18)T

205. -- 299. (RESERVED)

300. STANDARD OF LICENSURE -- PROTECTION OF PERSONS RESIDING AT THE FACILITY.
The facility must develop, implement, and monitor policies and procedures to ensure each person is allowed and encouraged to exercise his rights as citizens of the United States, and all persons must be accorded those civil rights provided in Title 66, Chapter 4, Idaho Code, except as otherwise provided in Section 66-1406, Idaho Code. These procedures must include a written document that outlines the person's rights, restrictions, and rules of the facility. (2-22-18)T

301. ADVOCACY AND ADVOCATE SELECTION.
With input from the person and the person's interdisciplinary team, the administrator of the facility must appoint an advocate for the person when the following exists: (2-22-18)T

01. Legal Guardian Unable to Participate. The person's legal guardian is unable or unwilling to participate, or is unavailable after reasonable efforts to contact them for participation have been made. (2-22-18)T

02. Person Unable to Make Informed Decisions. A person "lacks capacity to make informed decisions" as defined in Section 66-402(9), Idaho Code. The IDT must determine and document in the person's record the specific impairment that has rendered the person incapable of understanding his own rights. (2-22-18)T

03. Requested by Person or Guardian. An advocate is requested by the person or his guardian. (2-22-18)T

04. Advocate Selection. The administrator must assure that all persons are represented only by individuals who are not employed by the facility and that person preference is honored whenever possible and appropriate. The priority for selection of advocates will be in the following order: (2-22-18)T

a. Parent(s); (2-22-18)T

b. An interested family member; or (2-22-18)T

c. Other interested parties. (2-22-18)T

05. Advocate Limitations. A person's advocate cannot make legal or other decisions on behalf of the person. The role of the advocate is limited to assisting the person in exercising his rights within the facility and as a United States citizen. (2-22-18)T

302. RIGHTS, RESTRICTIONS, AND RULES OF THE FACILITY -- DOCUMENTATION.
The facility must ensure each person, each person's legal guardian, and each person's advocate is provided with comprehensive facility information including each person's rights, restrictions, rules, services available, and potential charges for care. If legal guardians wish for other members of the person's family to be informed, they must put this permission in writing. The fact that a person has been determined to be incompetent or incapable does not absolve the facility from providing the person with such information to the extent that the person is able to understand them. (2-22-18)T

01. Provided with Rights, Restrictions, and Rules. Upon admission, a notice communicating rights information must be provided verbally and in writing in the manner and language understood by the person and the person's legal guardian, and the person's advocate, who will also acknowledge receipt of this notice in writing. If the person refuses to acknowledge receipt of the notice, the staff member delivering the notice will note the refusal on the receipt. The signed receipt, or copy of refusal will be maintained in the person's record. At a minimum, the information on record at admission must include the following: (2-22-18)T

a. Documentation demonstrating the receipt and explanation of each person rights, including the person's right to participate in accordance with person-centered care principles and his right to be free from abuse, neglect, mistreatment, and suspicious injuries of unknown source;; (2-22-18)T

b. Documentation demonstrating the receipt and explanation of written policies, procedures, or rules of the facility pertaining to the following: (2-22-18)T

i. Implementation and monitoring of trauma-informed care principles; (2-22-18)T

ii. For the management of conduct between staff and persons; (2-22-18)T

iii. For the management of maladaptive behavior; (2-22-18)T

iv. For the use of restraint during emergency situations and the facility's methods for the reduction and elimination of restraint use; (2-22-18)T

v. For suicide precautions; (2-22-18)T

vi. For filing a grievance; and (2-22-18)T

vii. For appealing treatment and re-admission decisions. (2-22-18)T

c. Contact information must be provided, including the phone number and mailing address for the following: (2-22-18)T

i. Facility personnel responsible for receiving allegations of abuse, neglect, and mistreatment and reporting suspicious injuries of an unknown source; (2-22-18)T

ii. Facility personnel responsible for receiving grievances and treatment appeals; and (2-22-18)T

iii. Adult Protection Services, the state protection and advocacy system, and the Department's Division of Licensing and Certification. (2-22-18)T

02. **Written Interpretation of Evaluations.** Upon request, a copy of the evaluation or a written interpretation of the evaluation that is conducted for the person must be provided to the person, the person's legal guardian, and the person's advocate within thirty (30) days of admission to the facility. Upon request, the administrator of the facility must provide a written interpretation of any and all subsequent evaluations. (2-22-18)T

03. **Be informed of Risks and Benefits.** The facility must explain the relative risks and benefits of specific modes of treatment contained in each person's Individual Treatment Plan (ITP) to the person, the person's guardian, and the person's advocate. The attendant risks of treatment must describe the risk vs. risk and the risk vs. benefit associated with the treatment. These risks include possible side effects, other complications from treatments including medical and drug therapy, unintended consequences of treatment, or other behavioral or psychological ramifications arising from treatment. (2-22-18)T

04. **Be Informed of Activities.** Each person's legal guardian or the person's advocate must be informed of activities related to the person that may be of interest to them. (2-22-18)T

05. **Notification of Significant Events.** Each person's legal guardian or advocate must be notified in the event of any unusual occurrence or significant changes in the person's condition including serious injury, illness, or accident, impending death, or death. Notifications must be made as soon as possible, but must not exceed twenty-four (24) hours. (2-22-18)T

06. **Communications.** Each person's legal guardian or advocate must receive replies to any communication sent to the facility regarding the person within forty-eight (48) hours. (2-22-18)T

303. FACILITY ENVIRONMENTAL RESTRICTIONS.

01. **Locked, Fenced, and Enclosed Grounds Accessible to Persons, Staff, and Authorized Individuals.** The facility must develop, implement, and monitor policies and procedures governing the use of locked, fenced, and enclosed grounds. Policies must identify the circumstances under which fencing is to be unlocked and the procedures specifying how each person, staff, and authorized individuals will gain access. (2-22-18)T

02. **Locked Residential Units.** The facility must develop, implement, and monitor policies and procedures governing the use of locked residential units. Policies must identify the circumstances under which the units are to be unlocked and the procedures specifying how each person, staff, and authorized individuals will gain access to locked units. Locked units must not be used as a substitute for adequate staff, staff convenience, or a treatment plan. (2-22-18)T

03. **Bedroom and Building Exit Alarms.** The facility must develop, implement, and monitor policies and procedures governing the use of bedroom and building exit alarms. Policies must identify the circumstances under which the alarms are to be used. Alarms must not be used in lieu of sufficient staff, for staff convenience, or as a substitute for a treatment plan. (2-22-18)T

04. **Video and Audio Monitoring.** The facility must develop, implement, and monitor policies and procedures governing the use of video and audio monitoring. The facility may install video and audio equipment for the purposes of monitoring persons in common areas only. Video and audio monitoring in bathrooms, bedrooms, or in areas where the person is visiting with his attorney, an employee at the attorney's firm, or a representative of the state protection and advocacy system is prohibited. Video and audio monitoring must not be used in lieu of sufficient staff, for staff convenience, or as a substitute for a treatment plan. (2-22-18)T

05. **Restricted Access to Items That Could Be Used as Weapons.** The facility must develop, implement, and monitor policies and procedures that restrict access to facility items and equipment that could be used as weapons. Facility policies must specify which items will be permanently restricted and which items may be temporarily restricted. For temporary restrictions, procedures must be established for the return of access based on individualized assessment. Restricted access to items must not be used in lieu of sufficient staff, for staff convenience, or as a substitute for a treatment plan. (2-22-18)T

304. RIGHTS THAT MAY NOT BE RESTRICTED.

01. **Right to Care in a Safe Setting.** Each person is entitled to humane care and treatment in the environment or setting that is least restrictive of personal liberties in which appropriate treatment can be provided. Each person is entitled to be diagnosed, cared for, and treated in a manner consistent with his legal rights and in a manner no more restrictive than necessary for his protection and the protection of others for a period no longer than reasonably necessary for diagnosis, care, treatment, and protection. (2-22-18)T

02. **Right to Be Free from Abuse, Neglect, and Mistreatment.** The facility must implement, through policies, oversight, and training, safeguards to ensure that each person is not subjected to abuse, neglect, or mistreatment by anyone including facility staff, consultants, contractors, staff of other agencies serving the person, family members, legal guardians, advocates, friends, other persons, themselves, or members of the public. The facility must adhere to the following: (2-22-18)T

a. The facility must prohibit the employment of individuals with a conviction or prior employment history of abuse, neglect, or mistreatment of a child or of a person residing in a care facility. (2-22-18)T

b. Through established procedures, the facility must ensure that all allegations of abuse, neglect, mistreatment, and suspicious injuries of unknown origin are reported immediately to the administrator and to other officials according to with state law, including law enforcement agencies and adult protective services under Section 39-5303, Idaho Code. (2-22-18)T

c. The facility must have evidence that all alleged violations are thoroughly investigated. (2-22-18)T

d. The facility must prevent further potential abuse while the investigation is in progress. (2-22-18)T

e. The results of all investigations must be reported to the administrator within five (5) business days of the investigation's start date. (2-22-18)T

f. If the alleged violation is verified, the person's trauma history must be immediately updated, the impacts of the trauma must be assessed, and the person's comprehensive functional assessment, Individual Treatment Plan (ITP), and programs must be reviewed and updated under Section 440 of these rules. All other appropriate

corrective action must be taken as soon as is reasonable. (2-22-18)T

03. **Right to Be Free from Unnecessary Drugs.** All persons have the right to be free from unnecessary drugs. Drugs must not be used without indication, in excessive doses, or for excessive durations that interfere with the person's daily living activities. Chemical restraint imposed as a means of coercion, punishment, convenience, or retaliation by staff constitutes abuse. (2-22-18)T

04. **Right to Be Free from Unnecessary Physical Restraint and Seclusion.** All persons have the right to be free from seclusion and unnecessary physical restraint. Seclusion and prone restraint, supine restraint and any other restraint that forces a person against a hard surface such as a wall, chair, or the floor is not allowed. Other physical restraints may only be used to ensure the immediate physical safety of the person, a staff member, or others, and must be discontinued at the earliest possible time based on an individualized person assessment and re-evaluation. Restraint of any form imposed as a means of coercion, punishment, convenience, or retaliation by staff constitutes abuse. (2-22-18)T

05. **Right to Free Access to Attorney and Advocacy.** Every person in the facility must, at all times, have the right to visit and be visited by or to communicate by sealed mail, telephone, or otherwise with the person's attorney, an employee at the attorney's firm, or a representative of the state protection and advocacy system. Each person must have reasonable access to letter-writing material and postage for this purpose. (2-22-18)T

06. **Right to Practice Religion.** The facility must honor each person's religious preferences and practices, including providing religiously necessary food accommodations. If the person's right to participate in community activities has been restricted, according to Subsection 310.01 of these rules, the facility must make other arrangements such as telecommunication or in-person visits with religious personnel, necessary to ensure the person's rights to practice religion is upheld. (2-22-18)T

07. **Right to Be Paid for Work Performed.** A person must not be compelled to perform services for the facility. Persons who do work for the facility must be compensated for their efforts at prevailing wages. (2-22-18)T

08. **Right to Voice Grievances.** Each person and his representatives must be provided free access to established procedures to voice grievances and to recommend changes in policies and services being offered at the facility. The facility must have an established grievance process for prompt resolution of grievances and must inform each person whom to contact to file a grievance. At a minimum, the facility policy must include the following: (2-22-18)T

a. A clearly explained procedure for the submission of a person's written or verbal grievance to the facility; (2-22-18)T

b. Specific time frames for review of the grievance and the provision of a response; and (2-22-18)T

c. In its resolution of the grievance, the facility must provide the person or his representative with written notice of its decision that contains the name of the facility staff contact, the steps taken on behalf of the person to investigate the grievance, the results of the grievance process, and the date of completion. (2-22-18)T

09. **Right to Appeal Treatment Decisions.** The person, the person's attorney, and the person's legal guardian or advocate may appeal any treatment decisions that limit the person's rights to the facility's Human Rights Committee (HRC) within thirty (30) calendar days of receipt of the written statement and a notice of appeal rights, under Subsection 310.06 of these rules. (2-22-18)T

10. **Right to Participate.** Each person has the right to participate in the development of his Individual Treatment Plan (ITP). The ITP must be a person-centered plan of care, which ensures each person's rights to participate are upheld, including, the following: (2-22-18)T

a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the ITP. (2-22-18)T

b. The right to participate in establishing the expected goals and outcomes of care, the type, amount frequency, and duration of care, and any other factors related to the effectiveness of the ITP. (2-22-18)T

c. The right to be informed, in advance, of changes to the ITP. (2-22-18)T

d. The right to receive the training and services included in the ITP. (2-22-18)T

305. -- 309. (RESERVED)

310. RIGHTS THAT MAY BE RESTRICTED.
The decision to limit a person's rights must accord with Title 66, Chapter 14, Idaho Code. Limitations or any restrictive treatment that may infringe on person's rights, must be a clinical decision made as part of the person's Individual Treatment Plan (ITP). The facility must seek the written informed consent of the person and the person's legal guardian. (2-22-18)T

01. Limitations on Communication, Visitation and Participation in Social and Community Events. Except as provided in Subsections 304.05 and 304.06 of these rules, the facility may limit a person's rights to communicate with individuals inside or outside the facility or to receive visitors or associate freely with other individuals. (2-22-18)T

02. Limitations on Personal Possessions. The facility may permanently and temporarily restrict a person's right to keep and use the person's own personal possessions. (2-22-18)T

i. Permanent restrictions while the person resides at the facility may include the restriction of items that may be used as weapons such as knives, baseball bats, hammers, screwdrivers, rocks, weights, lighters, knitting needles, hand-held mirrors, CDs, DVDs, glass or porcelain nick-knacks, neckties, necklaces, nylons, and other items that are not considered supportive or adaptive equipment, communication devices, or basic clothing. (2-22-18)T

ii. Temporary restrictions may include the restrictions of supportive or adaptive equipment, or basic clothing that may be used as weapons such as eye glasses, canes, walkers, belts, socks, and shoelaces. Removal of such items must only occur if the removal is necessary to ensure the immediate physical safety of the person, a staff member, or others. Any removal of supportive or adaptive equipment that compromises a person's mobility must be returned to the person immediately if the person indicates a desire to move through verbal, physical, or other means. All items must be returned as soon as the physical safety situation has been resolved. Removal of communication devices is not allowed. (2-22-18)T

03. Limitations on Financial Management. The facility may limit a person's rights to manage his financial affairs when a person chooses to purchase items, such as weapons, that are contraindicated in the person's Individual Treatment Plan (ITP). (2-22-18)T

04. Limitations on Personal Privacy. The facility may limit a person's personal privacy in situations where a person must be continuously observed to ensure his safety, such as when a person is under suicide precautions. (2-22-18)T

05. Limitations on Access to Records. The facility may limit a person's access to his records when such access results in violent or self-destructive behavior or a deterioration in the person's mental health status. The reason for restricted access to records, including the person-centered Individual Treatment Plan (ITP) and all revisions must be clearly documented. The person's record must also clearly document any alternative measures the facility has taken to ensure the person's right to participate is upheld under Subsection 304.10 of these rules. Direct care staff may not limit access unless the restriction has been incorporated into the person's ITP as stated in Section 310 of these rules. (2-22-18)T

06. Right to Refuse or Revoke. The facility must inform each person, the person's legal guardian, and the person's advocate of the right to refuse treatment or revoke consent for treatment without fear of reprisal. (2-22-18)T

a. A person, or a person's legal guardian who refuses or revokes consent for a particular treatment, such as a behavior control measure, seizure control medication, a particular intervention strategy or a specific mode of treatment or habilitation, either verbally or in writing, must be offered information about acceptable alternatives to the treatment, if acceptable alternatives are available. (2-22-18)T

b. The person's preference about alternatives are to be elicited and considered in deciding on the course of treatment. If the person or the person's legal guardian also refuses the alternative treatment, or if no alternative exists to the treatment, the facility must consider the effect this refusal may have on the health and safety of other persons and the person himself. (2-22-18)T

c. If treatment refusals or the revocation of consent presents a significant health and safety risk to other persons or the person himself, treatment may be given over the objections of the person and the person's legal guardian when allowable according to applicable law. The decision to limit a person's rights is a clinical decision made by the Interdisciplinary Team (IDT) as part of the person's Individual Treatment Plan (ITP) and according to physicians' orders. (2-22-18)T

d. If treatment is given over an objection, a statement explaining the reasons for such limitations must be entered in to the person's record immediately. Copies of the statement and a notice of treatment decision appeal rights must be sent to the court that committed the person, the person's attorney, the person's legal guardian, the person's advocate, and the Human Rights Committee within one (1) business day of the Interdisciplinary Team's decision. The notice of treatment decision appeal rights must include the following: (2-22-18)T

i. A description of how to request an appeal; (2-22-18)T

ii. The deadline to request the appeal and what to do if the deadline is missed; and (2-22-18)T

iii. The contact information of the person designated to coordinate the appeal process. (2-22-18)T

311. -- 319. (RESERVED)

320. WRITTEN INFORMED CONSENT REQUIRED.
The facility must provide each person and the person's legal guardian with the information required to make an informed decision about the person's care related to the person's medical condition, developmental status, mental health status, and behavioral status. When a person does not have a legal guardian, the person's advocate must be provided sufficient information necessary to assist the person in decision-making only. The person's advocate cannot make decisions or provide consent on the person's behalf. (2-22-18)T

01. Written Informed Consent Required for Proposed Restrictive Treatment. The facility must seek the written informed consent from the person and the person's legal guardian for any restrictive treatment and other practices that may infringe on person's rights. Consents must be obtained prior to the implementation of the proposed restriction. Experimental research is not allowed. Written informed consent must be time-limited and include the following: (2-22-18)T

a. The specific treatment; (2-22-18)T

b. The reason for treatment; (2-22-18)T

c. The attendant risks vs. benefits of the treatment; (2-22-18)T

d. Alternatives to the proposed treatment; (2-22-18)T

e. Right to refuse the proposed treatment without fear of reprisal; (2-22-18)T

f. The consequences associated with consent or refusal of the proposed treatment; and (2-22-18)T

g. The right to revoke consent without fear of reprisal. (2-22-18)T

321. FUNCTION OF THE HUMAN RIGHTS COMMITTEE.

01. **Primary Function.** The primary function of the Human Rights Committee is to protect person rights by monitoring facility practices and programs necessary to ensure that each person's rights are protected. There must be evidence that the committee members have been provided with initial, ongoing, and refresher training on trauma-informed care principles, person-centered care principles, methods to reduce and eliminate restraint use, rights of the people residing at the facility, what constitutes a restriction of a right, and the difference between punishment and training. Initial training must be provided prior to the HRC's review of facility policies and procedures, person interventions, person appeals, and person grievances. Refresher training must be provided annually. (2-22-18)T

02. **Policies and Role of the Committee.** The facility will develop policies for the committee that includes the composition of the committee members, including qualifications and what number constitutes a quorum. The role of the committee will be outlined to include the following: (2-22-18)T

a. Review and approval, prior to implementation, of any procedure or treatment that the person or the person's legal guardian has refused or revoked, for which there is no known acceptable alternative treatment, and for which the treatment team has presented a clinical decision to limit the rights; (2-22-18)T

b. Review facility policies and practices to ensure that they are consistent with trauma-informed care principles, person-centered care principles, applicable law, and these rules and present feedback to the facility on any concerns noted; (2-22-18)T

c. Review revisions of procedures and treatments that increases the level of intrusiveness of restrictive interventions the HRC previously approved; (2-22-18)T

d. Review appeals of treatment decisions; and (2-22-18)T

e. Participate in reviewing grievances under the grievance policy. (2-22-18)T

322. DOCUMENTATION OF HUMAN RIGHT COMMITTEE REVIEW, APPROVAL, AND MONITORING.

01. **Documentation of Human Rights Committee Review and Approval.** Documentation to verify that the committee completed a thorough, substantive review of all restrictive practices and interventions, except environmental restrictions outlined in Section 303 of these rules. Periodic monitoring by the committee must ensure trauma-informed principles and person-centered care principles are adhered to and include the following: (2-22-18)T

a. An assessment supporting the need for the restrictive intervention; (2-22-18)T

b. Evidence the intervention has been approved for use at the facility, under policy; (2-22-18)T

c. Evidence the severity of the behavior outweighs the risks of the proposed intervention; (2-22-18)T

d. Evidence that less restrictive interventions were considered; (2-22-18)T

e. Evidence that an individualized behavior plan to reduce the need for the restrictive intervention has been developed and implemented; (2-22-18)T

f. Evidence that replacement behavior training is present and functionally related to each maladaptive behavior; (2-22-18)T

g. Evidence that the committee ensured that the person, the person's legal guardian, and the person's advocate was actively involved in the development of the assessment, proposed intervention, alternatives, and plan and written informed consent from the person's legal guardian was obtained; (2-22-18)T

h. Documentation of any changes required by the committee prior to approval; (2-22-18)T

i. The frequency of the committee's review of the person's progress and approval of the restrictive intervention; and (2-22-18)T

j. The time limit of the committee's approval. (2-22-18)T

02. **Documentation of Objection of Restrictive Measures Overridden**. According to Subsection 310.06 of these rules, the Interdisciplinary Team (ITD) may implement restrictive measures over the objection of the person and the person's legal guardian. In those situations, the Human Rights Committee (HRC) must review the interventions and the objection (if available) prior to giving approval. The Interdisciplinary Team will not implement restrictive measures over the objection of the HRC. (2-22-18)T

323. -- 399. (RESERVED)

400. STANDARD OF LICENSURE: TREATMENT AND SERVICES.
The facility must implement a person-centered Individual Treatment Plan (ITP) that is developed and designed to achieve the person's discharge from the facility at the earliest possible time. (2-22-18)T

401. ADMISSION RECORDS.
Each person's record must clearly document admission to the facility was in conformance with all admission criteria found in Title 66, Chapter 14, Idaho Code. Each person's record must include the following: (2-22-18)T

01. **Documentation of basic information**. The person's name, age, level of intellectual or developmental disability, serious mental illness diagnosis, other relevant diagnoses, who to contact in case of an emergency, and other significant events must be documented. (2-22-18)T

02. **Documentation of Court Findings**. Documentation from the court regarding criminal adjudication and evaluation for competency or treatment to restore competency, civil commitment to the custody of the Department, or determination of the presence of a substantial threat to the safety others if not evaluated or treated in the facility. (2-22-18)T

402. ADMISSION PROCESS.
Upon admission, each person must be immediately evaluated to ensure safe and appropriate treatment is provided upon admission. The preliminary evaluation must contain background information obtained from the person and the person's guardian and the person's advocate that includes a comprehensive trauma history and de-escalation strategy information, as well as currently valid assessments of basic functioning. (2-22-18)T

01. **Medical and Physical History Assessment**. Upon admission, each person must have a comprehensive medical history and physical assessment completed by the physician. At a minimum, the assessment must include the following: (2-22-18)T

a. A complete head to toe examination of all person body systems; (2-22-18)T

b. Documentation of immunization status; (2-22-18)T

c. An assessment for the risk to a person if they require restraint, including limitations on any restraint based on the person's needs and medical condition; (2-22-18)T

d. Orders signed by the physician for all drugs and biologicals required by the person; (2-22-18)T

e. Documentation of any medication allergies or adverse drug reactions the person has experienced; and (2-22-18)T

f. Documentation of any food allergies and a diet order signed by the physician. (2-22-18)T

02. **Comprehensive Trauma History and De-escalation Strategy Information**. Upon admission, the clinical case manager must complete a comprehensive trauma history and gather information regarding strategies that

may be implemented to de-escalate the person during periods of agitation and distress. Information must be obtained from the person and the person's guardian and the person's advocate. (2-22-18)T

a. At a minimum, the trauma history must include: (2-22-18)T

i. Physical abuse; (2-22-18)T

ii. Sexual abuse and rape; (2-22-18)T

iii. Victimization due to other crimes; (2-22-18)T

iv. Neglect; (2-22-18)T

v. Acute trauma, such as a severe accident or natural disaster; (2-22-18)T

vi. Witnessing a death or violence toward someone else; (2-22-18)T

vii. Being subjected to seclusion, including the form, frequency, and duration of the seclusion, physical restraints, including the form, frequency, and duration of restraints used, and punishment, including the form, frequency, and duration of the punishment used; and (2-22-18)T

viii. As applicable, what trauma-related effects the person is experiencing, such as flashbacks, nightmares, insomnia, fearfulness, self-injury or aggression, and triggering events such as yelling, hearing loud noises, a certain time of day or year, a particular task or activity, or frequent prompts to engage in activities that results in increased difficulty for the person. (2-22-18)T

b. At a minimum, de-escalation information must include: (2-22-18)T

i. Identification of strategies that have worked for the person in the past, such as taking a walk with staff, listening to music, talking with someone, or deep breathing; (2-22-18)T

ii. Identification of other individuals who have been helpful to the person during previous upsetting situations; and (2-22-18)T

iii. Identification of actions or events that may cause additional distress when the person is already upset, such as being touched, being isolated, being prompted to engage in tasks or activities, or being told to calm down. (2-22-18)T

03. **Assessment of Abilities and Needs.** At the time of admission and upon completion of the person's trauma history and de-escalation strategy information, the clinical case manager must assess each person's basic functioning abilities and needs. All assessments must include information obtained from the person, the person's guardian, and the person's advocate and identify those areas that are deemed to be important to the person. The assessment must also incorporate all relevant information obtained from the trauma history and de-escalation strategy information, including the identification of any task, activity or event that the person may find re-traumatizing, and the psychological impacts a re-traumatizing situation may have on the person. At a minimum, assessments must include the following areas: (2-22-18)T

a. Basic activity of daily living skills including toileting, personal hygiene, dental hygiene, dining, bathing, dressing, grooming, and self-administration of medication; (2-22-18)T

b. Receptive and expressive communication of basic needs, including the person's verbal and non-verbal expression of illness, pain, and discomfort; (2-22-18)T

c. Supportive or adaptive equipment needs; (2-22-18)T

d. Mental health and behavioral status, including the person's ability to recognize, report, and cope with any symptoms they may be experiencing, which intervention strategies are recommended, and which

intervention strategies to avoid. If restrictive interventions are to be implemented upon admission, the assessment must clearly document the need for the interventions; (2-22-18)T

e. If physical restraint are to be used, the assessment must include a trauma history, documenting any past trauma, physical, sexual or psychological abuse, and the psychological effect that restraint may have by re-traumatizing the person. The assessment must include any restraints that will not be used based on past trauma. Aftercare instructions to staff must be provided; and (2-22-18)T

f. Any other pertinent information that contributes to an overall understanding of the person's level and quality of functioning. (2-22-18)T

403. FORMATION OF THE PRELIMINARY PLAN.

01. **Preliminary Plan Required.** Immediately following the basic admission assessments, the clinical case manager must formulate a preliminary plan for staff to follow in meeting each person's immediate needs. The preliminary plan must include input from the person and the person's guardian and the person's advocate. (2-22-18)T

02. **What the Preliminary Plan Must Include.** From the time of admission until the time the Individual Treatment Plan (ITP) is implemented, the facility must provide those services and activities determined to be essential to the person's daily functioning as specified on the person's preliminary plan. Staff must receive specific training on the preliminary plan prior to working with the person directly. The preliminary plan must incorporate all assessment recommendations, with particular emphasis given to those recommendations which the person and the person's guardian and the person's advocate deemed to be important and those that were based on the person's trauma history and de-escalation strategy information. At a minimum, the preliminary plan must include the following: (2-22-18)T

a. Basic information including the person's name, age, level of intellectual or developmental disability, other relevant diagnoses, and information-related areas that were identified as important to the person; (2-22-18)T

b. Basic physical health information including any physical health related concerns identified by the physician in the admission history and physical, medication allergies, adverse drug reactions, medications prescribed and times of medication administration. If PRN medications are prescribed, information must include a specific set of symptoms which indicate the need for PRN medication; (2-22-18)T

c. Staffing and specific supervision needs, including any enhanced supervision, such as line of sight during all hours, line of sight during all waking hours except when the person is engaged in independent personal care activities, or arm's length supervision; (2-22-18)T

d. The level of assistance staff must provide the person to perform each basic activity of daily living, and to engage in interests, activities and hobbies; (2-22-18)T

e. Information related to food allergies and any dietary restrictions or modifications; (2-22-18)T

f. How to communicate with the person, including the person's verbal and nonverbal expression of illness, pain, discomfort, and distress; (2-22-18)T

g. Signs and symptoms of mental illness the person displays, what may trigger an escalation of mental health symptoms, how to intervene, and what interventions to avoid; (2-22-18)T

h. Maladaptive behaviors the person engages in what conditions, activities, tasks, and events may result in the person engaging in maladaptive behavior, how to intervene, and what interventions to avoid. If the physician or the clinical case manager has determined there is a health or psychological risk to utilizing restraint, the Interdisciplinary Team (IDT) must insure that the preliminary plan clearly states the prohibition of restraints and must identify alternative measures to use in an emergency situation; and (2-22-18)T

i. If physical restraint is to be used, the preliminary plan must include aftercare instructions to staff;

and (2-22-18)T

j. Any other pertinent information that contributes to an overall understanding of the person's level and quality of functioning. (2-22-18)T

404.--409. (RESERVED)

410. COMPREHENSIVE FUNCTIONAL ASSESSMENT.
Within fourteen (14) calendar days after admission, the Interdisciplinary Team (IDT) must have completed assessments or reassessments as needed, to supplement the preliminary assessment completed upon admission. All assessments must include information obtained from the person, the person's guardian, and the person's advocate and identify those areas that are deemed to be important to the person. All assessments must incorporate all relevant information obtained from the trauma history and de-escalation strategy. (2-22-18)T

01. Accurate Assessment. Assessments must be accurate and administered with appropriate adaptations such as specialized equipment, use of an interpreter, use of manual communication and tests designed to measure performance in the presence of visual disability. (2-22-18)T

a. Assessment data must be current, relevant and valid. Assessment data from assessments completed in a previous placement or as part of the court's determination to place the person in the facility can be used to meet this requirement if those assessments were completed within the past six months, and the assessments are reviewed and updated for relevance and validity. (2-22-18)T

b. Stated in specific functional terms, including specific information about the person's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment; (2-22-18)T

c. Identify skills, abilities, and training needs that correspond to the person's actual, observed status; and (2-22-18)T

d. Include conclusions and recommendations on which to base Individual Treatment Plan (ITP) priority decisions. (2-22-18)T

02. Assessments Completed by Appropriate Personnel. The separate components of the comprehensive assessment must be completed by appropriate personnel. Professional expertise may fall within the purview of multiple professional disciplines, based on overlapping training and experience. The facility's policies must specify which discipline or disciplines are responsible for completing each assessment area. All personnel must receive training on trauma-informed care principals and person-centered care under Subsection 204.02 of these rules, and review the person's trauma history and de-escalation strategy information prior to conducting his portion of the comprehensive functional assessment. (2-22-18)T

411. COMPONENTS OF THE COMPREHENSIVE FUNCTIONAL ASSESSMENT.
Assessments must include identification of those functional life skills in which the person needs to be more independent and those services needed for the person to more successfully manage maladaptive behaviors and mental health symptoms. All assessments must be consistent with trauma-informed care principles and person-centered care principles, and include recommendations that actively avoid re-traumatizing the person when applicable. Components of the comprehensive functional assessments must include the following: (2-22-18)T

01. Assessment of Placement. The assessment must include an evaluation of the circumstance under which the person was admitted to the facility and the specific barrier(s) that the person must overcome in order to be discharged to a less restrictive setting. (2-22-18)T

02. Assessment of Adaptive Behavior and Independent Living Skills. To the degree possible considering the limitations in the facility, the assessment must include the effectiveness or degree with which the person meets the standards of personal independence, social responsibility and community orientation and integration expected of his age and cultural group. (2-22-18)T

03. **Assessment of Presenting Problems and Disabilities and Their Causes.** The assessment must include all of the person's diagnoses and intellectual or developmental deficits and the supporting information for each. (2-22-18)T

04. **Assessment of Physical Development, Health Status, Strengths and Needs.** The assessment must include the person's developmental history, results of the history and physical examination conducted by a licensed physician, health assessment data, including a medication and immunization history, and when available, a review and summary of all laboratory reports and reports of all specialist consultations. The assessment must include the person's skill level in the monitoring and supervision of one's own health status, and the ability to administer one's own medications and treatments. (2-22-18)T

05. **Assessment of Sensorimotor Development.** The assessment must include motor development that addresses those behaviors that primarily involve muscular, neuromuscular, or physical skills and varying degrees of physical dexterity, and an assessment of perceptual skills, including auditory functioning and vision, that are involved in making sense of environmental stimuli. Identified sensory deficits will be evaluated in conjunction with the impact they will have on the person's life. (2-22-18)T

06. **Assessment of Adaptive Equipment.** For those motor areas that are identified by the assessment as limited, the assessment will specify the extent to which corrective, orthotic, prosthetic, or support devices would impact the person's functional status and the extent of time the device is to be used throughout the day. The assessment must include the specific accommodations that address the person's needs to ensure better opportunity for the person's success. The identified accommodations may be assistive technology that can help a person to learn, play, complete tasks, get around, communicate, hear or see better, control his own environment and take care of his personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.). (2-22-18)T

07. **Assessment of Cognitive Function and Developmental Status, Strengths and Needs.** The assessment must include the person's development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving. It is also the identification of different learning styles the person has and those best used by the trainers. It is critical that the assessment address the individual learning style of the person in order to best direct the way the trainers will teach formal and informal programs. (2-22-18)T

08. **Assessment of Nutritional Status, Strengths and Needs.** The assessment must include the person's height, weight, ideal body weight, the person's eating habits, religious preferences and accommodations, favorite foods, determination of appropriateness of diet, including the person's desire to lose or the need to gain weight, adequacy of total food intake, bowel habits, means through which the person receives nutrition, and the skills associated with eating including chewing, sucking, and swallowing disorders. (2-22-18)T

09. **Assessment of Speech and Language (Communication) Development.** The assessment must address both verbal and nonverbal and receptive and expressive communication skills. Assessment data must identify the appropriate intervention strategy to be applied, and which augmentative or assistive devices, if any, will improve communication and functional status. Recommendations for intervention strategies must provide the person with a viable means of communication that is appropriate to his sensory, cognitive, and physical abilities. The assessment must identify if or how frustration caused by a lack of effective means to communicate contributes to the person's maladaptive behaviors. (2-22-18)T

10. **Assessment of Mental Health.** Each person must receive a psychiatric evaluation that includes the person's diagnosis and treatment, to include a history of when the person's symptoms presented, were diagnosed and if possible, by whom. Information related to the effectiveness of prior treatments and information necessary to support the person's current diagnosis and treatment must be present. In those cases where the mental status portion of the psychiatric evaluation is performed by a nonphysician, there is the expectation of evidence that the nonphysician is licensed and credentialed by the facility, legally authorized by the state to perform that function, and a physician review and countersignature is present, where required by facility policy or state law. (2-22-18)T

11. **Assessment of Behavioral Status, Strengths and Needs.** The assessment must address and

identify the skill deficits that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports are to be done within the context of the person's age, gender, and culture. (2-22-18)T

a. The assessment must include the development of behaviors that relate to one's interests, attitudes, values, morals, emotional feelings, and emotional expressions. (2-22-18)T

b. The functional behavioral assessment must look beyond the behavior itself. The functional behavioral assessment must identify significant person-specific physical, social, affective, cognitive, and environmental factors associated with the occurence (and nonoccurence) of specific behaviors. The functional behavioral assessment must identify the purpose of the specific behavior(s) and recommend interventions to directly address the function of the behavior(s). (2-22-18)T

12. **Assessment to Support the Need of Restrictions**. If restrictive interventions are to be used, the assessment must clearly document the behaviors the person engages in to support the need for the restriction. If the physician or the clinical case manager has determined there is a health or psychological risk to utilizing restraint, the Interdisciplinary Team (IDT) must ensure that the assessment clearly states the prohibition of restraints and must identify alternative measures to use in an emergency situation. (2-22-18)T

412. PROFESSIONAL SERVICES AVAILABLE.
The comprehensive functional assessment must identify the course of specific interventions recommended to meet the person's needs, both through direct professional services and nonprofessional services. The person's needs identified in the comprehensive functional assessment must guide the Interdisciplinary Team (IDT) in deciding if a particular professional's involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis. (2-22-18)T

413.--419. (RESERVED)

420. INDIVIDUAL TREATMENT PLAN (ITP).
The Interdisciplinary Team, including the person, the person's legal guardian, the person's advocate, and any other individual identified as important to the person, including those identified when gathering de-escalation information, must collaboratively develop the person's Individual Treatment Plan (ITP) treatment plan within five (5) calendar days of the completion of the Comprehensive Functional Assessment. When professional assessments have been completed, recommendations to address the person's needs must be presented to the Interdisciplinary Team (IDT) at the person's ITP meeting.

01. **Mandatory Participation**. Professional participation may be through written reports or verbally while attending the ITP meeting, in person, via telephone, or by other electronic means. This participation provides team members with the opportunity to review and discuss information and recommendations relevant to the person's needs, and to reach decisions as a team, rather than individually, on how best to address those needs. All recommendations must be incorporated into the person's ITP, with a current prioritized objective. ITP documentation must demonstrate the person's right to participate was upheld in accordance with Subsection 304.10 of these rules. (2-22-18)T

02. **Clinical Case Manager Responsibilities**. Each person's treatment program must be integrated, coordinated and monitored by a clinical case manager. The clinical case manager is ultimately responsible for the overall responsiveness and effectiveness of each person's treatment program. (2-22-18)T

03. **Development of the Individual Treatment Plan (ITP).** Each person must receive a continuous treatment program that includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. The Individual Treatment Plan (ITP) is the outline of what the facility has committed itself to do for the person, based on an assessment of the person's needs. The plan must be consistent with trauma-informed care principles and person-centered care principles and contain the following: (2-22-18)T

a. The person's strengths, needs, areas deemed to be important by the person, and the person's trauma history and de-escalation strategy information; (2-22-18)T

b. Substantiated diagnoses; (2-22-18)T

c. Short-term and long range goals of the desired outcomes the person is trying to achieve and projected completion dates based on the person's rate of learning; (2-22-18)T

d. Specific, separately stated, measurable priority and secondary objectives necessary to meet the person's training needs, as identified by the comprehensive assessment; (2-22-18)T

e. Specific, separately stated, measurable priority and secondary objectives necessary to meet the person's service and support needs, as identified by the comprehensive assessment; (2-22-18)T

f. Specific treatment modalities utilized, with the following requirements: (2-22-18)T

i. The focus of the treatment must be included. Simply naming modalities such as individual therapy, group therapy, occupational therapy, and medication education is not acceptable. (2-22-18)T

ii. Modality approaches must be specifically described in order to ensure consistency of approach. Simply stating modality approaches, such as set limits, encourage socialization, and discharge planning as needed is not acceptable. (2-22-18)T

g. Any additional adaptive equipment, assistive technology, services and supports required to meet the person's needs: (2-22-18)T

h. The specific steps and actions that will be taken to achieve the established objectives; (2-22-18)T

i. The responsibilities of each member of the Interdisciplinary Team; and (2-22-18)T

j. Adequate documentation to support the diagnosis and treatment activities carried out. (2-22-18)T

421. DEVELOPMENT OF INDIVIDUALIZED WRITTEN TRAINING AND SERVICE PROGRAMS.

01. Written Training and Service Programs. Written training and service programs must be developed for each priority objective identified in the Individual Treatment Plan (ITP). (2-22-18)T

02. Program Specifications. Each written training and service programs must specify the following: (2-22-18)T

a. The specific methods or treatment modalities to be used and those that are specifically prohibited based on the person's trauma history and de-escalation information; (2-22-18)T

b. The schedule for use of the methods or treatment modalities; (2-22-18)T

c. The staff member responsible for the program and identification of staff who may implement the program; (2-22-18)T

d. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives; (2-22-18)T

e. Any triggers, mental health symptom(s), inappropriate behavior(s), including those identified in the person's trauma history and de-escalation information, that are specifically related to the program; (2-22-18)T

f. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior with behavior that is adaptive or appropriate, including those identified in the person's de-escalation information; (2-22-18)T

g. A description of relevant interventions to support the person toward independence, provide

opportunities for personal choice and self-management, and include the areas identified as important to the person and the person's self-identified de-escalation strategies; (2-22-18)T

h. Identify the location where program strategy information, that must be accessible to any person responsible for implementation, can be found; and (2-22-18)T

i. Specific instructions to staff regarding how to respond if the person refuses to engage in the activities specified in the written program. (2-22-18)T

422. REQUIRED EQUIPMENT AND SUPPLIES.

01. Equipment and Supplies. The equipment and supplies needed to implement each written program, including adaptive equipment and mechanic supports must be identified to achieve proper body position, balance, or alignment. (2-22-18)T

02. Plan Specifications. The plan must specify the following: (2-22-18)T

a. The reason for each support; (2-22-18)T

b. The situations in which each is to be applied; and (2-22-18)T

c. A schedule for the use of each support. (2-22-18)T

423. IMPLEMENTATION OF THE INDIVIDUAL TREATMENT PLAN (ITP).
As soon as the interdisciplinary team has formulated a person's Individual Treatment Plan (ITP), each person must receive a continuous treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the Individual Treatment Plan (ITP) in both structured and nonstructured situations. Staff must receive specific training on the implementation of the ITP at the time of implementation. (2-22-18)T

01. Individualized Treatment Schedules. The facility must develop and implement a treatment schedule that outlines the person's treatment program, that must be readily available for review by relevant staff. Each person must be actively involved in the development of his schedule in accordance with Subsection 304.10 of these rules (2-22-18)T

02. Professional and Licensed Staff Services. The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions under the stated objectives of each person's Individual Treatment Plan (ITP). (2-22-18)T

a. Each person must receive the professional program services needed to implement the treatment program defined by each person's Individual Treatment Plan (ITP). Professional program staff must work directly with each person. For those services that must be provided by a professional due to law, licensure or registration, the person must receive the services directly from the professional. (2-22-18)T

b. Professional program staff must work directly with paraprofessional, nonprofessional, and other professional program staff who work directly with the person. Professionals may deliver services through the supervision and direction of subordinates where provided by law. (2-22-18)T

03. Unlicensed Staff Responsibilities. Except for those facets of the Individual Treatment Plan (ITP) that must be implemented only by licensed personnel, each person's ITP must be implemented by all staff who work with the person, including professional, paraprofessional and nonprofessional staff. (2-22-18)T

a. An Individual Treatment Plan (ITP) may not require that professional staff perform all of the services as outlined by the ITP; and (2-22-18)T

b. Direct Care Staff may be trained by the professional staff to safely and effectively carry out the

written program. In these situations, the appropriate professional must evaluate the staff's competencies in plan delivery at periodic intervals. (2-22-18)T

424--429. (RESERVED)

430. DATA COLLECTION.
Documentation. Each person's record must be a comprehensive, accurate representation of the person's status, care, and treatment. (2-22-18)T

01. **Documented Program Data.** Program data must be documented in measurable terms and collected in the form and at the frequency specified on each written program; (2-22-18)T

02. **Documentation Requirements.** Documentation must ensure that all therapeutic efforts received by the person are included; and (2-22-18)T

03. **Significant Events.** Significant events that are related to the person's Individual Treatment Plan (ITP) and assessments that contribute to an overall understanding of the person's ongoing level and quality of functioning must be documented. For all traumatic significant events, the person's trauma history must be immediately updated, the impacts of the trauma must be assessed, and the comprehensive functional assessment, ITP, and programs must be reviewed and updated under Section 440 of these rules. (2-22-18)T

431. CHRONIC, PERVASIVE REFUSALS TO PARTICIPATE.

01. **Active Engagement.** The facility must actively attempt to engage persons to participate in activities specified in their Individual Treatment Plans (ITPs). (2-22-18)T

02. **Refusal Policies and Procedures.** The facility must develop, implement and monitor policies and procedures that address a person's chronic, pervasive pattern of refusals to participate in treatment. Policies must address the following: (2-22-18)T

a. Refusals that do not impact the person's health and safety, such as refusing to engage in housekeeping activities; and (2-22-18)T

b. Refusal that may impact a person's health and safety, such as refusing to eat, refusing to take medications, refusing vaccinations, and refusing to engage in personal and dental hygiene. (2-22-18)T

i. The facility's policies must address the circumstances under which forced compliance will be implemented, such as when a person refuses to take medications, and how forced compliance will be achieved. The person's physician must document the reason why the task or activity is necessary and critical to the person's health and safety prior to the use of forced compliance. (2-22-18)T

ii. The facility's policies must address the circumstance in which the facility must consider alternative placement options due to a person's persistent refusals to participate that jeopardizes the health and safety of the person or others or significantly impedes the facility's ability to meet the person's treatment needs. Discharge and transfer policies must adhere to Section 441 of these rules. (2-22-18)T

432 -- 439. (RESERVED)

440. PROGRAM MONITORING AND CHANGE.

01. **Clinical Case Manager Review and Revision.** The person's comprehensive functional assessment, and Individual Treatment Plan (ITP) must be reviewed and updated by the clinical case manager at least monthly and as necessary, including situations in which: (2-22-18)T

a. The person has successfully completed an objective or objectives identified in the Individual Treatment Plan (ITP); (2-22-18)T

b. The person has regressed or lost skills already gained; (2-22-18)T

c. The person has failed to progress toward identified objectives after reasonable efforts have been made; (2-22-18)T

d. The person is being considered to work toward new objectives; or (2-22-18)T

e. The comprehensive assessment of the person's strengths and needs has changed based on the occurrence of a significant event. For all traumatic significant events, the person's comprehensive functional assessment, ITP, and programs must be reviewed and updated by the appropriate professional personnel to address the impacts of the new traumatic event. The person's record must include documentation that all changes have been communicated and discussed with the interdisciplinary team, including the person, prior to the change being made. (2-22-18)T

02. **Interdisciplinary Team Review and Revision**. The person's comprehensive functional assessment and Individual Treatment Plan (ITP) must be reviewed at least every ninety (90) days by Interdisciplinary Team (IDT) and revised as necessary. The IDT review must include participation of the person, the person's guardian, and the person's advocate. (2-22-18)T

03. **Interdisciplinary Team 90-Day Review**. Upon completion, the IDT's 90-day review must be immediately forwarded to the Director to determine whether the person continues to meet facility criteria under Subsection 441.02 of these rules. The IDT review must include the following: (2-22-18)T

a. Documentation of review and discussion of the person's current status and significant events, including traumatic significant events and how those events have impacted the person; (2-22-18)T

b. Documentation of review and discussion of the person's progress toward all objectives and documentation of any recommendations and changes to be made to the person's treatment program; (2-22-18)T

c. Documentation of a re-evaluation of all restrictive interventions and documentation of any recommendations and changes to be made to the person's restrictive interventions; and (2-22-18)T

d. Documentation of a re-evaluation of placement at the facility. (2-22-18)T

i. Documentation must include the specific criteria supporting the continued placement of the person at the facility; or (2-22-18)T

ii. Documentation of any recommendations and changes to be made to the person's living situation, including transfer and discharge from the facility. (2-22-18)T

441. TRANSFER OR DISCHARGE FROM THE FACILITY.
Except in emergencies, the Director must have documentation in the person's record that the person was transferred or discharged for good cause. (2-22-18)T

01. **Transfer or Discharge Based on Emergent Needs**. If a person is deemed to need medical care or acute psychiatric care, it is the responsibility of the facility to ensure a timely transfer based on the urgent or emergency nature of symptoms or injury presentation. The person's legal guardian, advocate, and the Director must be immediately notified of the transfer or discharge based on the person's emergent needs. (2-22-18)T

a. The facility must have a transfer agreement for the immediate transfer to a hospital for persons requiring emergency medical care beyond the capabilities of the facility. (2-22-18)T

b. The facility must have a transfer agreement for the transfer to a hospital with psychiatric services for persons requiring psychiatric care beyond the capabilities of the facility. (2-22-18)T

02. **Non-Emergency Discharge**. Upon receipt of the Interdisciplinary Team's 90-day review under Subsection 440.03 of these rules, the Director must determine and document whether the person continues to meet

secure facility program criteria. If the person no longer meets the program criteria, the Director must redisposition the person, under Section 66-1405, Idaho Code. If a person is to be either transferred or discharged, the facility must ensure the following: (2-22-18)T

a. Discharge for Good Cause. The facility must have documentation in the person's record that the person was transferred or discharged for good cause; and (2-22-18)T

b. Reasonable Preparation Time. The facility must provide a reasonable time to prepare the person, the person's legal guardian, and the person's advocate for the transfer or discharge, except in emergencies; and (2-22-18)T

c. Information Provided. At the time of transfer or discharge, medical and other information needed for care of the person in light of such a transfer, will be exchanged between the institutions according to federal and state medical privacy law, including: (2-22-18)T

i. Any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and (2-22-18)T

ii. A post-discharge plan of care that will assist the person to adjust to the new living environment. (2-22-18)T

442. -- 499. (RESERVED)

500. STANDARD OF LICENSURE: BEHAVIOR AND FACILITY PRACTICES.
The facility must provide each person with training, services and supports to increase his independence in the self-management of maladaptive behavior and mental health symptoms. (2-22-18)T

501. PROHIBITIONS.
The facility must not, under any circumstances, use interventions including: (2-22-18)T

01. Seclusion. (2-22-18)T

02. Aversive Conditioning. Adverse conditioning, including painful or noxious stimuli; (2-22-18)T

03. Barred Enclosures. Barred or other enclosures that do not meet the construction requirements of a time-out room under Subsection 502.02 of these rules; (2-22-18)T

04. Forced Compliance. Forced compliance for tasks and activities not related to health and safety; (2-22-18)T

05. Prone and Supine Restraints. Prone, supine, and any other restraint that forces a person against a hard surface such as a wall, chair, or the floor. (2-22-18)T

06. Physical Interventions and Hyperextension. Physical interventions that hyper-extend of any part of the body such as limbs, joints, fingers, and thumbs; (2-22-18)T

07. Physical Interventions and Pressure. Physical interventions that include pressure points, joint or skin twisting, or applying pressure or weight to the chest, lungs, sternum, diaphragm, back, abdomen, neck, throat, any major artery, or on the back of a person's neck or head, obstructing circulation or the person's airway; (2-22-18)T

08. Techniques Involving the Head. Any technique that involves using a person's head to control movement such as half nelsons, full nelsons, and headlocks; (2-22-18)T

09. High Risk Techniques. Any technique that involves substantial risk of injury such as wrestling holds and take downs; (2-22-18)T

10. **Tie-Down Devices to Stationary Objects.** Any tie-down device designed to secure a person to a stationary object, such as a bed or chair; (2-22-18)T

11. **Law Enforcement Restraint Devices.** Any use of law enforcement restraint devices, such as handcuffs, manacles, shackles, or other chain type restraint devices; (2-22-18)T

12. **Law Enforcement Weapons or Devices.** Any use of law enforcement weapons or devices used to subdue persons such as pepper spray, mace, nightsticks, tasers, cattle prods, stun guns, and riot gear; (2-22-18)T

13. **Other Techniques.** Any techniques imposed as a means of coercion, punishment, convenience or retaliation by staff or as a substitute for a treatment plan; and (2-22-18)T

14. **Behavior Interventions.** The use of standing or as needed behavior interventions. (2-22-18)T

502. POLICIES, PROCEDURES AND PRACTICES TO MANAGE MALADAPTIVE BEHAVIOR.
The facility must develop, implement, and monitor all practices and individualized interventions to ensure restrictive techniques are employed with sufficient safeguards to protect each person's health, safety, and rights. Any use of restrictive interventions that is not consistent with facility policy and these rules constitutes abuse and must be immediately reported to the facility administrator under Subsection 304.02 of these rules. The failure of staff to intervene to ensure a person's health and safety constitutes neglect and must also be immediately reported to the facility administrator under Subsection 304.02(b) of these rules. All policies, procedures, and practices used to manage a person's maladaptive behavior or mental health symptoms must be approved by facility administration and reviewed by the Human Rights Committee. Policies must be available to each person, staff, guardian, and advocate and must address the following: (2-22-18)T

01. **Conduct.** The facility must develop, implement, and monitor written policies and procedures for the management of conduct between staff and persons. These policies and procedures must be consistent with trauma-informed care principles and person-centered care principles in creating a culture that actively supports people in having control over their own treatment throughout all levels of the facility. These policies and procedures must: (2-22-18)T

a. Promote the growth, development, and independence of each person; (2-22-18)T

b. Specify person conduct to be allowed or not allowed; and (2-22-18)T

c. Be available to each person, staff, guardian, and advocate. (2-22-18)T

02. **Interventions Approved for Use.** The facility must develop, implement, and monitor written policies and procedures that identify all behavior interventions approved for use at the facility. These policies and procedures must designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive to least positive or most intrusive, and address the following: (2-22-18)T

a. Time-out room use. Exclusionary time-out procedures may include the use of a time-out room, from which egress is prevented only if the following conditions are met: (2-22-18)T

i. The placement is part of a systematic time-out program; (2-22-18)T

ii. Emergency placement of a person into a time-out room is not allowed unless the person's behavior places the person, staff, or others at immediate risk for harm and all other less-intrusive behavior interventions have been tried. (2-22-18)T

iii. The person is under the direct constant supervision of designated staff and the time-out is immediately discontinued if the person has an emergent need, such as needing to use the bathroom, or displays any physical signs or symptoms of distress such as seizure-like activity or labored breathing; (2-22-18)T

iv. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure

from a staff member to keep the mechanism engaged; (2-22-18)T

v. Placement of a person in a time-out room does not exceed one (1) hour; (2-22-18)T

vi. Each person placed in a time-out room must be protected from hazardous conditions including the presence of sharp corners and objects, uncovered light fixtures, and unprotected electrical outlets; (2-22-18)T

vii. A record of time-out activities must be kept; and (2-22-18)T

viii. Using a person's bedroom as a time-out room is not allowed. (2-22-18)T

b. Physical restraint use; (2-22-18)T

c. The use of drugs to manage inappropriate behavior; and (2-22-18)T

d. Forced compliance for health and safety related tasks and activities. The person's physician must document the reason why the task or activity is necessary and critical to the person's health and safety prior to the use of forced compliance. (2-22-18)T

03. **Sufficient Safeguards and Supervision**. The facility must develop, implement, and monitor written policies and procedures that ensure all interventions to manage each person's inappropriate behavior or mental health symptoms are employed with sufficient safeguards and supervision to ensure that the safety, welfare, and civil and human rights of the person are adequately protected. Monitoring of all intervention strategies must be an integral part of the facility's Quality Assessment Performance Improvement Program under Section 901 of these rules. These policies and procedures must: (2-22-18)T

a. Identify the staff members who may authorize the use of specified interventions; (2-22-18)T

b. Include a mechanism for monitoring and controlling the use of interventions; and (2-22-18)T

c. Include mechanisms for increased monitoring during the use of concurrent restrictive interventions such as chemical restraints used while a person is in physical restraint. (2-22-18)T

04. **Incorporated into Individual Treatment Plans (ITPs)**. The facility must develop, implement, and monitor written policies and procedures that ensure the systematic use of behavior interventions to manage inappropriate behavior are sufficiently incorporated into each person's Individual Treatment Plan (ITP). These policies and procedures must: (2-22-18)T

a. Specify the use of the person's individualized trauma history, de-escalation strategy, information, and mental health and behavior assessments in the development of all behavior management programs; (2-22-18)T

b. Specify expectation for the use of less restrictive interventions; (2-22-18)T

c. Specify restrictive programming must be designed to lead to less restrictive means of managing and eliminating the behavior for which the restriction is applied; and (2-22-18)T

d. Specify the identification and use of replacement behaviors that are clearly related to the function of the inappropriate behavior. (2-22-18)T

503. EMERGENCY USE OF RESTRICTIVE INTERVENTION FOR EMERGENCY MENTAL HEALTH AND BEHAVIORAL REASONS.
The facility must develop, implement, and monitor written policies and procedures that govern the use of restrictive interventions in cases of emergency. These policies and procedures must be consistent with physician's orders and must: (2-22-18)T

01. **Specify Restrictive Interventions**. Specify which restrictive interventions may be used in the event of a behavioral or mental health emergency; (2-22-18)T

02. **Ensure Appropriate Emergency Interventions.** Ensure emergency interventions are only employed when absolutely necessary to protect the person or others from injury when the person is exhibiting behaviors that he has not exhibited before and were not identified in the person's mental health or behavioral assessments; (2-22-18)T

03. **Specify Reporting and Documentation Requirements.** Specify reporting and documentation requirements for each emergency intervention use; (2-22-18)T

04. **Specify Required Re-evaluation.** Specify required re-evaluation of the person's trauma history, mental health and behavioral assessments, Individual Treatment Plan (ITP), and behavior programming after each emergency intervention is used; and (2-22-18)T

05. **Establish Criteria.** Establish criteria to ensure interventions are incorporated into a person's Individual Treatment Plan (ITP) when it can be reasonably anticipated the intervention will be regularly used. (2-22-18)T

504. EMERGENCY USE OF RESTRICTIVE INTERVENTION FOR PHYSICAL MEDICAL EMERGENCIES AND TREATMENT.
The facility must develop, implement and monitor written policies and procedures that governing the use of restrictive interventions for physical medical emergencies and treatment. These policies and procedures must ensure health-related protections and monitoring are prescribed by a physician, and used only if absolutely necessary for the person's protection during the time that a medical condition exists. (2-22-18)T

505. -- 509. (RESERVED)

510. SUICIDE PRECAUTIONS.
The facility must develop, implement and monitor written policies and procedures that governing the management of people who are suicidal. (2-22-18)T

01. **Suicidal Ideation Indicators.** The facility policies and procedures must include information to staff regarding verbal and nonverbal indicators of a person engaging in suicidal ideation. (2-22-18)T

02. **Immediate Action Taken.** The facility policies and procedures must address what immediate actions are to be taken in the event of suicidal ideation, threats, or attempt without significant injury, including: (2-22-18)T

a. Increased level of supervision and monitoring; (2-22-18)T

b. Room and property searches; (2-22-18)T

c. Body searches; and (2-22-18)T

d. Inventory and storage of any removed items. (2-22-18)T

03. **Notifications.** The facility policies and procedures must include who must be notified and documentation requirements. (2-22-18)T

04. **Suicide Risk Assessment.** The facility policies and procedures must include the facility's expectations for the completion of a suicide risk assessment. The policy must specify the following: (2-22-18)T

a. The qualifications and training required to complete suicide risk assessments; (2-22-18)T

b. When and how the initial risk assessment is to be completed; (2-22-18)T

c. Actions to be taken in response to assessment findings; (2-22-18)T

d. Frequency of re-evaluation; (2-22-18)T

e. Specific criteria and documentation for decreasing supervision and monitoring; and (2-22-18)T

f. Specific criteria and documentation for the return of any items taken. (2-22-18)T

05. **Documentation.** The facility policies and procedures must specify, that the person's mental health and behavioral assessment, Individual Treatment Plan (ITP), and programs must include comprehensive information and specific individualized intervention strategies for each person known to engage in suicidal ideation, or threats or actions that are person-centered and consistent with trauma-informed care principles. (2-22-18)T

06. **Action for Injury or Death.** The facility policies and procedures must address what immediate actions are to be taken in the event of a suicide attempt with significant injury or an actual suicide. (2-22-18)T

511. PHYSICAL RESTRAINT USE.
Restraint must only be used for the management of violent or self-destructive behavior after less restrictive interventions have failed. The use of any restraint must be immediately reported to the facility's administrator or designee. (2-22-18)T

01. **Prohibitions.** All persons require a physician and a clinical case manager to assess the risk to a person if they require restraint. If the physician or the clinical case manager identifies any risk to utilizing the restraint, Interdisciplinary Team (IDT) must ensure that the Individual Treatment Plan (ITP) identifies alternative measures to use in place of physical restraint. (2-22-18)T

02. **Conditions for Use.** Restraint must not be used unless the use of restraint is necessary to ensure the immediate physical safety of the person, a staff member, or others. The use of restraint must be discontinued as soon as possible based on an individualized assessment and re-evaluation of the person. (2-22-18)T

a. Restraints must be designed and used so as not to cause physical injury to the person and to cause the least possible discomfort. (2-22-18)T

b. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the person, a staff member, or others from harm. (2-22-18)T

c. The use of restraint must be implemented under safe and appropriate restraint techniques by trained staff. No less than two (2) staff must be physically present for continuous visual monitoring whenever restraint is employed. The use of excessive force, unapproved restraints, or improper restraint technique constitutes abuse and must be immediately reported to the administrator under Subsection 304.02(b) of these rules. (2-22-18)T

d. If the person being restrained has an emergent need, such as needing to use the bathroom or display any physical signs or symptoms of distress, such as labored breathing, blue color of the lips or mouth, flushing of the face or neck, pale skin color, excessive perspiration, or muscle spasms must be taken out of restraint immediately and the facility's registered nurse must be immediately notified. (2-22-18)T

e. A person must be released from physical restraint as quickly as possible. Restraints cannot be in effect longer than two (2) consecutive hours. (2-22-18)T

f. Except in emergencies, restraint must be used as an integral part of an Individual Treatment Plan (ITP) that is intended to lead to less restrictive means of managing the behavior or mental health symptoms for which restraint is used. Restraint must only be implemented according to a person's behavior management program that provides a clear description of the violent or self-destructive behavior the person engages that would warrant the need for restraint. The program must specify the following: (2-22-18)T

i. A description of the person's behavior that would indicate the need for restraint; (2-22-18)T

ii. Person-specific behavioral changes that indicate restraint is no longer necessary; and (2-22-18)T

iii. Aftercare instructions to staff regarding how to respond to and support the person after the restraint is released. (2-22-18)T

03. Monitoring and Documentation. The use of restraints and related monitoring of the person must be documented in the person's record. (2-22-18)T

a. The condition of the person who is restrained must be continuously visually monitored, in person, by no less than two (2) trained staff that have completed the training criteria specified in Subsection 204.02 of these rules. Video monitoring of restraint is not allowed. Monitoring documentation must include the following:(2-22-18)T

i. An evaluation of the person's circulation, skin integrity, hydration needs, elimination needs, breathing, level of distress, and agitation; and (2-22-18)T

ii. Entries every fifteen (15) minutes describing the continuous visual monitoring of a person in restraints. (2-22-18)T

b. Within twenty-four (24) hours or sooner as indicated by need, the nurse must complete a head to toe examination of any person placed in restraint. Any injuries noted must be immediately reported to the facility's administrator. (2-22-18)

04. Utilization Review. An interdisciplinary team review and debriefing must be completed and documented within seventy-two (72) hours of each restraint use. If the person refuses the opportunity to participate in the restraint debriefing, the refusal must be documented. All restraint use must be reviewed in conjunction with the person's trauma history, all applicable assessments, the Individual Treatment Plan (ITP), and programs. Review must include the following: (2-22-18)T

a. An analysis of triggers, antecedent behaviors, alternative behaviors, least restrictive or alternative interventions attempted, including identification of the person's de-escalation preferences must be included. The restraint uses and any injuries noted in the nursing assessment must also be evaluated as well as the effectiveness of the aftercare the person received. A plan of correction must be developed, implemented, and monitored for any identified concerns and the person's trauma history, assessments, Individual Treatment Plan (ITP), and programs must be updated as needed. (2-22-18)T

b. An interdisciplinary team comprehensive 90-day restraint review must be completed to identify patterns and trends in restraint use, including patterns in triggering events, in times of day, or staff involved. A plan of correction must be developed, implemented, and monitored for any identified concerns and the person's trauma history, assessments, Individual Treatment Plan (ITP), and programs must be updated as needed; (2-22-18)T

c. The Human Rights Committee must review the interdisciplinary team's 90-day restraint review findings and any corrective actions taken as a result of the review. The Human Rights Committee must document agreement with the actions taken or make additional recommendations; and (2-22-18)T

d. All restraint data, including the Interdisciplinary Team (IDT) and Human Rights Committee review, must be an integral part of the facility Quality Assessment and Performance Improvement Program to reduce restraint frequency and duration and improve safety. (2-22-18)T

512. -- 519. (RESERVED)

520. DRUGS USED TO MANAGE MENTAL HEALTH SYMPTOMS OR MALADAPTIVE BEHAVIOR. The facility must develop, implement and monitor policies and procedure governing the use of all drugs used for the management of mental health symptoms or maladaptive behavior, including the use of routine medications, PRN medication, and the use of emergency chemical restraints. (2-22-18)T

01. Prohibitions. Drugs used for the management of mental health symptoms or maladaptive behaviors must not be used: (2-22-18)T

a. Without justification; (2-22-18)T

b. For excessive durations that interfere with the person's daily living activities; and (2-22-18)T

c. Until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. (2-22-18)T

02. **Conditions for Use.** Medications used for the management of mental health symptoms or inappropriate behavior must be prescribed by a physician and administered as prescribed by trained staff who have been delegated the authority. (2-22-18)T

a. The facility must ensure emergency chemical restraints are only used when absolutely necessary to protect the person or others from injury when the person is exhibiting behaviors of a severity and intensity that he has not exhibited before. (2-22-18)T

i. The facility's registered nurse must assess the person before contacting the physician to request an emergency chemical restraint; and (2-22-18)T

ii. The physician must be contacted each time an emergency chemical restraint is requested. Standing or repeat chemical restraint orders are not allowed. (2-22-18)T

b. Except in emergencies, medications used for the management of mental health symptoms or inappropriate behavior must be approved by the Interdisciplinary Team (IDT) and be used only as an integral part of the person's behavior management program. The program: (2-22-18)T

i. Must be an integral part of the person's Individual Treatment Plan (ITP) that is directed toward the reduction of the mental health symptoms or maladaptive behavior for which the drugs are employed; (2-22-18)T

ii. Must include, for all PRN medication use, the person's ability to self-report a need for PRN medication and include PRN administration criteria based on the person's specific behavior or signs and symptoms of mental distress; and (2-22-18)T

iii. Must include specific behavioral criteria for when each medication will be increased or decreased based on the person's progress or regression towards the objectives establish in the person's Individual Treatment Plan (ITP). (2-22-18)T

03. **Monitoring and Documentation.** All drugs used for the management of mental health symptoms or inappropriate behavior must be documented in the person's record. (2-22-18)T

a. Drugs must be monitored closely for desired responses and adverse consequences by facility staff and in conjunction with the physician and the pharmacist. (2-22-18)T

b. If an emergency chemical restraint or PRN medication is given while a person is in physical restraint, documentation of the emergency chemical restraint or PRN effects must be completed every five (5) minutes until the physical restraint is discontinued. (2-22-18)T

c. The effectiveness of any emergency chemical restraint or PRN medication must be documented one (1) hour after the medication's administration and as needed based on peak onset of the drug. At a minimum, documentation must include pre and post behavior or mental health symptoms and pre and post assessment of the person's circulatory, respiratory, and neurological status at intervals appropriate to the drug administered. (2-22-18)T

04. **Utilization Review.** All emergency chemical restraint or PRN medication use must be reviewed. (2-22-18)T

a. An Interdisciplinary Team (IDT) review must be completed and documented within seventy-two (72) hours of each emergency chemical restraint or each PRN medication use to evaluate the events before, during, and after the use. If the person refuses the opportunity to participate in the review, the refusal must be documented.

All chemical restraint and PRN medication use must be reviewed in conjunction with the person's trauma history, all applicable assessments, the Individual Treatment Plan (ITP), and programs. A plan of correction must be developed, implemented, and monitored for any identified concerns; (2-22-18)T

b. In conjunction with the physician, an Interdisciplinary Team (IDT) comprehensive 90-day emergency chemical restraint and PRN medication review must be completed to identify patterns and trends in use, including patterns in triggering events, in times of day, staff involved, or need to re-evaluate the person's drug regimen. A plan of correction must be developed, implemented, and monitored for any identified concerns; (2-22-18)T

c. The Human Rights Committee (HRC) must review the Interdisciplinary Team (IDT) 90-day emergency chemical restraint and PRN medication review with the drug regimen re-evaluation. The HRC must document agreement with the actions taken, or make additional recommendations; and (2-22-18)T

d. All emergency chemical restraint and PRN medication data, including the Interdisciplinary Team (IDT) and Human Rights Committee (HRC) review must be an integral part of the facility Quality Assessment and Performance Improvement Program. (2-22-18)T

521. -- 599. (RESERVED)

600. STANDARD OF LICENSURE: HEALTH CARE SERVICES.
The facility must provide each person with health care services to ensure optimal levels of wellness. (2-22-18)T

601. PHYSICIAN SERVICES.
The facility must ensure the availability of physician services twenty-four (24) hours a day. (2-22-18)T

01. Physician Participation in Plan. A physician must participate in the establishment of each newly admitted person's initial Individual Treatment Plan (ITP) and, if appropriate, review and update the plan as necessary. (2-22-18)T

02. Use of Physician Assistants and Nurse Practitioners. With the exception of newly admitted persons, under Subsection 601.01 of this rules and to the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this Section. (2-22-18)T

03. Care Required. The facility must provide or obtain preventative and general care, including: (2-22-18)T

a. A complete history and physical examination upon admission, under Subsection 402.01 of these rules and no less than annually thereafter; (2-22-18)T

b. An evaluation of vision and hearing; (2-22-18)T

c. Immunizations as recommended by the Centers for Disease Control and Prevention; (2-22-18)T

d. Routine screening laboratory examinations as determined necessary by the physician; (2-22-18)T

e. Special studies when needed; and (2-22-18)T

f. Screening for tuberculosis appropriate to the facility's population. (2-22-18)T

602. NURSING SERVICES.
The facility must develop, implement, and monitor policies and procedures that delineate person care responsibilities for all nursing service personnel. Nursing services must be provided according to recognized standards of practice, state law, and according to each person's needs. (2-22-18)T

01. Participate in Treatment Planning. Licensed nursing staff must participation as appropriate in the development, review, and update of each person's Individual Treatment Plan (ITP) as part of the Interdisciplinary

Team (IDT). (2-22-18)T

02. Quarterly Examinations. The registered nurse must review each person's health status by a direct physical examination on a quarterly or more frequent basis depending on the person's needs. The review must: (2-22-18)T

a. Be recorded in the person's record; and (2-22-18)T

b. Result in any necessary action, including referral to a physician to address health problems. (2-22-18)T

03. Provide other Nursing Care. Nursing care will need to be completed as prescribed by the physician or identified by the person's needs and according to recognized standards of practice and state law. (2-22-18)T

04. Training. Nursing staff are to actively participate in the instruction to each person and staff in methods of infection control, in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs. (2-22-18)T

05. License to Practice. Nurses providing services in the facility must have a current license to practice in the state. (2-22-18)T

06. Sufficient for Needs. The facility must employ or arrange for licensed nursing services sufficient to care for each person's health needs. A licensed nurse, who is trained in the use of the facility's emergency equipment, must be available for emergency treatment, whenever there is a person in the facility. (2-22-18)T

07. Licensed Registered Nurses (RNs). The facility must utilize licensed registered nurses (RNs) as appropriate and required by state law to perform the health service specified in this Section. (2-22-18)T

08. Consultation. If the facility utilizes licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a licensed registered nurse (RN) to be available for verbal or on- site consultation to the licensed practical or vocational nurse. (2-22-18)T

09. Unlicensed Nursing Personnel. Unlicensed personnel who provide health care services must do so under the supervision of licensed personnel. (2-22-18)T

603. -- 609. (RESERVED)

610. DENTAL SERVICES.
The facility must provide or arrange for diagnostic and treatment services for each person from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. The facility must ensure comprehensive dental treatment services that include: (2-22-18)T

01. Emergency Treatment. The availability for emergency dental treatment on a 24 hour a day basis by a licensed dentist; (2-22-18)T

02. General Dental Care. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health; and (2-22-18)T

03. Diagnostic Services. Comprehensive dental diagnostic services must include: (2-22-18)T

a. A complete extra-oral and intra-oral examination, using all diagnostic aids necessary to properly evaluate the person's condition not later than one month after admission to the facility; (2-22-18)T

b. Periodic examination and diagnosis performed at least annually; (2-22-18)T

c. Radiographs when indicated and detection of manifestations of systemic disease; and (2-22-18)T

d. A review of the results of the examination and entry of the results in the person's dental record. (2-22-18)T

611. PHARMACY SERVICES.
The facility must provide or arrange for the provision of routine and emergency drugs and biologicals for each person. Drugs and biologicals may be obtained from community or contract pharmacists. (2-22-18)T

01. **Drug Regimen Review**. A pharmacist with input from the Interdisciplinary Team (IDT) must review the drug regimen of each person at least quarterly. The pharmacist must: (2-22-18)T

a. Report any irregularities, black box warnings, and off-label uses in each person's drug regimens to the prescribing physician and Interdisciplinary Team (IDT); (2-22-18)T

b. Prepare a record of each person's drug regimen reviews, which must be obtained by the facility; and (2-22-18)T

c. Participate, as appropriate, in the development, implementation, and review of each person's Individual Treatment Plan (ITP) either in person or through written report to the Interdisciplinary Team (IDT). (2-22-18)T

02. **Medication Administration Record**. An individual medication administration record must be maintained for each person. (2-22-18)T

03. **Organized System**. The facility must have an organized system for drug administration that identifies each drug up to the point of administration. The system must ensure the following: (2-22-18)T

a. All drugs are administered in compliance with the physician's orders; (2-22-18)T

b. All drugs, including those that are self-administered, are administered without error; (2-22-18)T

c. Unlicensed personnel administer only those forms of medication that state law permits; and (2-22-18)T

d. Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician. (2-22-18)T

04. **Drug Storage**. The facility must store drugs under proper conditions of sanitation, temperature, light, and humidity. (2-22-18)T

05. **Drug Security**. The facility must keep all drugs and biologicals secured according to federal and state law, except when being prepared for administration. Only authorized personnel may have access to the keys to the drug storage area. (2-22-18)T

06. **Controlled Drugs**. The facility must maintain records of the receipt and disposition of all controlled drugs. The facility must follow federal and state requirements for the reconciliation of controlled drugs. (2-22-18)T

07. **Drug Labeling**. Labeling of drugs and biologicals must be based on currently accepted professional principles and practices and include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. (2-22-18)T

08. **Drugs Removed from Use**. The facility must ensure outdated drugs and drug containers with worn, illegible, or missing labels are removed from use. (2-22-18)T

09. **Discontinued Drugs**. Drugs and biologicals packaged in containers designated for a particular person must be immediately removed from the person's current medication supply if discontinued by the physician.

(2-22-18)T

10. Self-Administration of Medication. Each person is taught to administer his own medications if the Interdisciplinary Team (IDT) determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. (2-22-18)T

a. The person's physician must be informed of the Interdisciplinary Team's decision that self-administration of medications is an objective for the person; and (2-22-18)T

b. No person self-administers medication until he demonstrates the competency to do so. (2-22-18)T

612. LABORATORY SERVICES.
The facility must arrange for the provision of laboratory services. (2-22-18)T

01. Certification Required. Laboratory services must be provided from a laboratory certified in the appropriate specialties and subspecialties of service necessary to meet each person's needs. (2-22-18)T

02. Waived Tests. A facility performing any laboratory service or test must have applied to and received a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. (2-22-18)T

613. -- 699. (RESERVED)

700. STANDARD OF LICENSURE: DIETETIC SERVICES.
Each person must receive a nourishing, well balanced diet including modified and specially prescribed diets. Unless otherwise specified by medical needs, the diet must be prepared at least according to the latest edition of the recommended dietary allowances of the Idaho Diet Manual as incorporated in Section 004 of these rules, adjusted for age, sex, disability, religious belief, and activity. Food purchase, storage, preparation and service may be provided directly by the facility or under a written agreement with an outside service provider. If provided according to written agreement, the facility must ensure the outside service provider complies with all applicable rules. (2-22-18)T

701. QUALIFIED DIETICIAN.
A qualified dietitian must be employed full-time, part-time, or on a consultant basis at the facility's discretion. If a qualified dietitian is not employed full-time, the facility must designate a staff member to serve as the director of food services, who is a certified food protection manager. (2-22-18)T

702. MENUS.
The dietitian must ensure menus are prepared in advance, provide a variety of foods at each meal, be different for the same days of each week and adjusted for seasonal changes, and include average portion sizes for menu items. Records of food actually served must be kept on file for thirty (30) days. (2-22-18)T

703. PURCHASING AND STORAGE OF FOOD.
Food provided directly or under written agreement must be purchased and stored, as follows: (2-22-18)T

01. Food Source. All food and drink must be obtained from an approved source identified in IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments"; (2-22-18)T

02. Record of Food Purchases. At a minimum, a record of food purchases that includes invoices for the preceding thirty (30) day period must be kept; and (2-22-18)T

03. Temperature Requirements. Each refrigerator and freezer must be equipped with a reliable, easily read thermometer to ensure the following guidelines are met: (2-22-18)T

a. Refrigerators must be maintained at forty-one (41°F) degrees Fahrenheit or below; and (2-22-18)T

b. Freezers must be maintained at ten (10°F) degrees Fahrenheit or below. (2-22-18)T

704. DIET ORDERS.

The person's Interdisciplinary Team (IDT), including a qualified dietitian and physician must prescribe: (2-22-18)T

01. **Modified and Special Diets.** All modified and special diets, including those used as a part of a program to manage inappropriate behavior; and (2-22-18)T

02. **Proposed Foods for Reinforcement of Adaptive Behavior.** Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the person's nutritional status and needs. (2-22-18)T

705. FOOD PREPARATION.
Food provided directly or according to written agreement must be prepared in a safe and sanitary manner and comply with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments." Food provide directly may be prepared in a location adjacent to the facility, away from care areas. (2-22-18)T

706. FOOD SERVICE.
Each person must receive at least three meals daily and nourishing snacks, at regular times comparable to normal mealtimes in the community. Food service may be provided directly or according to written agreement. (2-22-18)T

01. **Food to Be Served.** (2-22-18)T

a. In appropriate quantity; (2-22-18)T

b. At appropriate temperature; (2-22-18)T

c. In a form consistent with the developmental level of the person; and (2-22-18)T

d. In a palatable and attractive manner. (2-22-18)T

02. **Refusal of Food.** If a person refuses the food served, substitutions must be made within the same food group. (2-22-18)T

03. **Uneaten Food Served.** Food served to each person individually and uneaten must be discarded. (2-22-18)T

707. DINING AREAS, EQUIPMENT, AND SUPERVISION.
Unless otherwise specified by the physician or IDT in the person's ITP, each person must receive meals in appropriately equipped dining areas. The facility must: (2-22-18)T

01. **Provide Table Service.** Provide table service for each person who can and will eat at a table, including people who use wheelchairs; (2-22-18)T

02. **Provide Proper Equipment and Furniture.** Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental, behavioral and mental health needs of each person; and (2-22-18)T

03. **Provide Sufficient Staff.** Provide sufficient staff to ensure the following: (2-22-18)T

a. Supervise and direct self-help dining procedures; (2-22-18)T

b. Ensure that each person receives enough food; (2-22-18)T

c. Ensure that each person eats in a manner consistent with his developmental level; and (2-22-18)T

d. Ensure that each person eats in an upright position. (2-22-18)T

708. -- 799. (RESERVED)

800. STANDARD OF LICENSURE: PHYSICAL ENVIRONMENT.
The requirements of Sections 800 through 899 of these rules are in addition to the NFPA's Life Safety Code and

IDAPA 07.03.01, "Rules of Building Safety." In addition to compliance with the standards set forth herein, the facility must comply with all building codes, ordinances, and regulations that are enforced by city, county, or other local jurisdictions in which the facility is located, or will be located. (2-22-18)T

801. ENVIRONMENTAL SANITATION STANDARDS.
The facility must ensure that its environment promotes the health, safety, and treatment of each person in the facility. (2-22-18)T

802. ENVIRONMENTAL STANDARDS -- WATER, SEWER, AND GARBAGE.

01. Water Supply. The facility must have a water supply that is adequate, safe, and of a sanitary quality. The water supply must be from an approved public or municipal water supply. (2-22-18)T

02. Adequate Water Supply. The facility must have a sufficient amount of water under adequate pressure to meet sanitary and fire sprinkler system requirements of the facility at all times, according to the requirements in IDAPA 07.02.06, "Rules Concerning Idaho State Plumbing Code," and the NFPA Life Safety Code incorporated in Section 004 of these rules. (2-22-18)T

03. Sewage Disposal. The facility must discharge all sewage and liquid wastes into a municipal sewage system. (2-22-18)T

04. Garbage and Refuse Disposal. The facility must provide garbage and refuse disposal at its facility that meets the following requirements: (2-22-18)T

a. The premises and all buildings must be kept free from accumulation of weeds, trash, and rubbish; (2-22-18)T

b. Materials not directly related to the maintenance and operation of the facility must not be stored on the premises; (2-22-18)T

c. All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and must not leak. Containers must be provided with tight-fitting lids unless stored in a vermin-proof room or enclosure; (2-22-18)T

d. Garbage containers must be maintained in a sanitary manner. Sufficient containers must be afforded to hold all garbage and refuse that accumulates between periods of removal from the facility; and (2-22-18)T

e. Storage areas must be kept clean and sanitary. (2-22-18)T

803. ENVIRONMENTAL STANDARDS -- CHEMICALS AND PESTICIDES.

01. Rodent and Pest Control. The facility must be maintained free from insects, rodents, vermin, and other pests. (2-22-18)T

a. Chemicals and pesticides must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer that is registered with the Idaho Department of Agriculture; and (2-22-18)T

b. Chemicals and pesticides used in the facility's pest control program must be used and stored to meet local, state, federal requirements, and must be stored outside of the facility. (2-22-18)T

02. Chemical Storage. All toxic chemicals must be properly labeled and stored outside of the building in a secured shed when not in use. Toxic chemicals must not be stored in individual areas, with drugs, or in any area where food is stored, prepared, or served. (2-22-18)T

804. ENVIRONMENTAL STANDARDS -- LINENS AND LAUNDRY SERVICES.

01. **Linens Provided.** The facility must have available at all times a quantity of linens sufficient for the proper care and comfort of its persons according to their ITPs. The linens must: (2-22-18)T

a. Be of good quality, not threadbare, torn, or badly stained; and (2-22-18)T

b. Be handled, processed, and stored in an appropriate manner that prevents contamination. (2-22-18)T

02. **Laundry Facilities.** The facility must have adequate laundry facilities for the sanitary washing and drying of the linens and other washable goods laundered in the facility. A person's personal laundry must be collected, sorted, washed, and dried in a sanitary manner, and must not be washed with the general linens. The laundry area must: (2-22-18)T

a. Be situated in an area separate and apart from where food is stored, prepared, or served; (2-22-18)T

b. Be well-lighted and ventilated; (2-22-18)T

c. Be adequate in size for the needs of the facility; (2-22-18)T

d. Be maintained in a sanitary manner; and (2-22-18)T

e. Be kept in good repair. (2-22-18)T

805. ENVIRONMENTAL STANDARDS -- HOUSEKEEPING SERVICES.
The facility must have sufficient housekeeping and maintenance personnel and equipment to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. (2-22-18)T

01. **Facility Interior.** Floors, walls, ceilings, and other interior surfaces, equipment, and furnishings must be maintained in a clean and sanitary manner. (2-22-18)T

02. **Housekeeping Procedures.** The facility must have written procedures for cleaning surfaces and equipment that is explained to each person engaged in housekeeping duties. (2-22-18)T

03. **Requirements after Discharge.** After discharge of a person, the facility must ensure that the person's room is thoroughly cleaned, including the bed, bedding, linens, and furnishings. (2-22-18)T

04. **Deodorizers.** Deodorizers and other products must not be used to cover odors caused by poor housekeeping or unsanitary conditions. (2-22-18)T

05. **Housekeeping Equipment.** All housekeeping equipment must be in good repair and maintained in a clean and sanitary manner. (2-22-18)T

806. -- 829. (RESERVED)

830. PHYSICAL FACILITY STANDARDS CONSTRUCTION REQUIREMENTS.
The facility must comply with IDAPA 07.03.01, "Rules of Building Safety," or with locally adopted code when more stringent. In addition to the construction and the physical facility standards for new construction, a facility must also comply with applicable Sections of these rules. Additions to existing facilities and portions of facilities undergoing remodeling or alterations other than repairs, must meet the NFPA Life Safety Code, as incorporated in Section 004 of these rules. (2-22-18)T

831. REQUIREMENTS FOR BUILDING CONSTRUCTION AND PHYSICAL STANDARDS.
The goals of these rules are to provide an environment for the occupants that are reasonably safe from fire and similar emergencies. (2-22-18)T

01. **Facility Life Safety Code Requirements.** (2-22-18)T

a. The facility must meet the provisions of the NFPA Life Safety Code as incorporated in Section 004 of these rules, applicable to facility. (2-22-18)T

b. The facility must be constructed to house persons and staff on the first floor only. (2-22-18)T

02. **Plans and Specifications**. Plans and specifications for the proposed new facility construction, any addition or remodeling are governed by the following: (2-22-18)T

a. Plans must be prepared by an architect or engineer licensed in the state of Idaho. A variance of this requirement may be granted by the Licensing and Survey Agency when the size of the project does not necessitate involvement of an architect or engineer; (2-22-18)T

b. Plans and specifications must be submitted to the Licensing and Survey Agency to ensure compliance with applicable construction standards, codes, and regulations; (2-22-18)T

c. Plans must be drawn to scale but not less than a scale of one-eighth (1/8) inch to one (1) foot; (2-22-18)T

d. Plans may be submitted electronically; (2-22-18)T

e. Plans must use the physical address as approved by the city; (2-22-18)T

f. Plans must include life safety plans; (2-22-18)T

g. Plans must include fire alarm shop drawings; and (2-22-18)T

h. Plans must include fire sprinkler system drawings and calculations. (2-22-18)T

03. **Approval by Department's Division of Licensing and Certification**. The Department's Division of Licensing and Certification will review and approve plans and specifications to ensure compliance with the applicable construction standards, codes, rules, and regulations prior to beginning any construction work. (2-22-18)T

04. **Toilet and Bathrooms.** The facility must provide sanitary facilities that prevent self-harm to persons and include at least one (1) public toilet, tub or shower, and lavatory in each building. (2-22-18)T

a. A toilet and bathroom for person use must be arranged so that it is not necessary for an individual to pass through another person's room to reach the toilet or bath; (2-22-18)T

b. Solid walls must separate each toilet and bathroom from all adjoining rooms; (2-22-18)T

c. Floors must be seamless and sealed; (2-22-18)T

d. Mechanical ventilation must vent to the outside; (2-22-18)T

e. Touch-tap systems must be installed for sinks; (2-22-18)T

f. Water shutoff valve must be located outside the rooms; (2-22-18)T

g. All light switches must be automatic; (2-22-18)T

h. Toilet must have no exposed piping; (2-22-18)T

i. Toilets must be of an electronic type with flood control devices; (2-22-18)T

j. Toilets must have fixed seats; (2-22-18)T

k. Lavatories must have solid surface material with an integral sink; (2-22-18)T

l. Shower controls must be recessed stainless steel panels; (2-22-18)T

m. Accessible (ADA) showers must have a dual head; (2-22-18)T

n. Showers must be designed to prevent the need for shower curtains; and (2-22-18)T

o. Floor drains must be sealed. (2-22-18)T

05. **Electrical Installations and Emergency Lighting.** Electrical installations and emergency lighting must be installed according to the manufacturer's specification and NFPA Life Safety Code and mandatory references therein, incorporated in Section 004 of these rules. (2-22-18)T

a. Maintain all electrical equipment in good repair and safe operating condition; (2-22-18)T

b. Electrical Panels installed inside the facility must be secured with a suitable keyed locking device and the keys must be accessible only to authorized personnel only; (2-22-18)T

c. The use of any type of extension cords, relocatable power taps, outlet strips, multi-plug adapters are strictly prohibited inside or outside the facility or facility grounds; (2-22-18)T

d. Emergency power must be arranged to provide the required power automatically in the event of any interruption of normal power; and (2-22-18)T

e. The emergency power must be arranged to automatically operate within ten (10) seconds upon failure of normal power and to maintain the necessary power source for a minimum of ninety (90) minutes. (2-22-18)T

06. **Lighting.** The facility must provide adequate lighting in all person sleeping rooms, dining rooms, living rooms, recreation rooms, and hallways. (2-22-18)T

07. **Ventilation.** The facility must be ventilated and precautions must be taken to prevent offensive odors. (2-22-18)T

08. **Plumbing.** All plumbing in the facility must comply with local and state codes. All plumbing fixtures must be easily cleanable and maintained in good repair. The temperature of hot water at plumbing fixtures used by persons must be between one hundred five degrees (105°F) Fahrenheit and one hundred twenty degrees (120°F) Fahrenheit. (2-22-18)T

09. **Heating, Air Conditioning and Ventilation.** Heating, air conditioning, piping, boilers, and ventilation equipment must be furnished, installed, and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes. (2-22-18)T

832. -- 839. (RESERVED)

840. STRUCTURE, MAINTENANCE, EQUIPMENT TO ENSURE SAFETY.
The facility must be structurally sound, maintained, and equipped to ensure the safety of persons, personnel, and the public must be in compliance with the NFPA Life Safety Code incorporated in Section 004 of these rules. In addition, the following special requirements for secured facilities must be provided: (2-22-18)T

01. **Doors.** Doors must be made of a material that cannot be easily damaged by pulling off pieces that could be used for harmful purposes and must meet the requirements of the NFPA Life Safety Code and include the following requirements: (2-22-18)T

a. Door must be swing outward with hinges mounted on outside; (2-22-18)T

b. Solid core wood or steel; (2-22-18)T

c. Door handles (if applicable) must be located on the exterior of the door; (2-22-18)T

d. Lock with keyed (manual or electronic) entry only and that is equipped with a device that automatically disengages in case of an emergency; (2-22-18)T

e. All doors will limit the passage of smoke; (2-22-18)T

f. Doors must be ligature-resistant; and (2-22-18)T

02. **Portable Heating Devices.** Portable heating devices of any kind are prohibited to include portable electric space heaters, movable fuel-fired heaters, electric fire places, and heating pads or blankets. (2-22-18)T

03. **Wall Projections.** Placement of items on the wall must prohibit ligature. (2-22-18)T

a. Drinking fountains are to be secured to the wall and visible to staff; and (2-22-18)T

b. Wall mounted thermostat must not be placed in person room. (2-22-18)T

04. **Light Fixtures.** Light fixture coverings must be secure and of break-resistant material. Tamper-resistant screws or attachment devices must be used, and the light fixtures are not to create an anchor point. Lighting and other ceiling mounted items are to be recessed or surface mounted to the ceiling with vandal-resistant fixtures, pull chains are not permitted. (2-22-18)T

a. Except for emergency egress lighting, all artificial lighting must be controllable by switches or automatic sensors; (2-22-18)T

b. Lighting must be provided for all rooms and include safety features; (2-22-18)T

c. Staff must have the ability to dim the light rather than turning on a full overhead light in the room to observe person; and (2-22-18)T

d. Light switches must be located on the outside of the person sleeping room. (2-22-18)T

05. **Window Frames.** Frames must be tamper-resistant and shatter-resistant and tested to make sure that they cannot be broken apart. (2-22-18)T

06. **Window Coverings.** Shades or blinds must: (2-22-18)T

a. Be located inside of window panes; (2-22-18)T

b. Not contain attached cords or ropes, and curtains must not be used; (2-22-18)T

c. Have hardware that is flush with the wall; and (2-22-18)T

d. Be tamper-proof. (2-22-18)T

07. **Dietary Facilities.** The food service facilities and equipment must comply with IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments," and food service facilities must be designed and equipped to meet the requirements of the facility. These may consist of an onsite conventional food preparation system, a convenience food service system, or an appropriate combination thereof. (2-22-18)T

08. **Functional Elements for Food Services.** The following facilities must be provided and be appropriately sized to implement the type of food service system selected: (2-22-18)T

a. Control station for receiving food supplies; (2-22-18)T

b. Storage space to accommodate a one (1) week supply of staple foods and a two (2) day supply of perishable foods; (2-22-18)T

c. Food preparation facilities as required by the program. Conventional food preparation systems require space and equipment for preparing, cooking and baking. Convenience food service systems such as frozen prepared meals, bulk-packaged entrées, individually packaged portions, or systems using contractual commissary services will require space and equipment for thawing, portioning, cooking or baking, or both; (2-22-18)T

d. Handwashing station in the food preparation area; (2-22-18)T

e. Meal service space including facilities for tray assembly and distribution; (2-22-18)T

f. Warewashing in a room or an alcove separate from food preparation and serving areas. This must include commercial type dishwashing equipment. Space must also be provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using area. Handwashing facilities must be conveniently available; (2-22-18)T

g. Pot washing facilities; (2-22-18)T

h. Waste storage facilities that are easily accessible for direct pickup or disposal; (2-22-18)T

i. Office or suitable work space for the dietitian or food service supervisor; (2-22-18)T

j. Toilets for dietary staff with handwashing facility immediately available; and (2-22-18)T

k. Janitor's closet located within the dietary department. The closet must contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. (2-22-18)T

09. **Dining Areas.** The facility must provide one (1) or more attractively furnished, multi-purpose areas of an adequate size for person's dining, diversional, and social activities. Each area must be: (2-22-18)T

a. Well-lighted; (2-22-18)T

b. Ventilated; and (2-22-18)T

c. Equipped with tables and chairs that are secured or heavy enough to prevent from lifting and have easily cleanable surfaces. (2-22-18)T

10. **Bathroom Accessories.** (2-22-18)T

a. Mirrors in person bathrooms must be reflective polycarbonate with a stainless steel frame firmly anchored to the wall. No shelf is to be part of this frame assembly; (2-22-18)T

b. Toilet paper holder must be ligature-resistant spindle button recessed; (2-22-18)T

c. Grab bars, as required for accessible rooms, must be fixed to the wall with a welded horizontal plate on the bottom of the bar. No swinging grab bars are to be used; (2-22-18)T

d. Clothing or towel hooks must be designed to collapse when any weight above four (4) pounds; (2-22-18)T

e. Paper towel dispensers, if installed, must be recessed; and (2-22-18)T

f. Soap dispensers must be wall-mounted with sloped tops or a suitable recessed dispenser. (2-22-18)T

11. **Storage Areas.** The facility must provide general storage areas. (2-22-18)T

a. Suitable storage must be provided for personal clothing, possessions, and individual adaptive equipment; (2-22-18)T

b. Safe and adequate storage space must be provided for medical supplies and an area appropriate for the preparation of medications; and (2-22-18)T

c. Medical gases must be stored and labeled in racks or fastenings to protect cylinders from accidental damage or dislocation. (2-22-18)T

12. **Accessibility for Persons with Mobility and Sensory Impairments.** For persons with mobility or sensory impairments, the facility must provide a physical environment that meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. Construction must meet the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities must comply, to the maximum extent feasible, with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers according to the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and must provide as required, the necessary accommodations: (2-22-18)T

a. Ramps for persons who require assistance with ambulation must comply with the requirements of the ADAAG; and (2-22-18)T

b. Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the ADAAG 4.13. (2-22-18)T

13. **Emergency Medical Equipment.** The facility medical staff and program administration must develop, implement and monitor policies and procedures to specify the types of emergency equipment required for use in the facility and must be immediately available for use during emergency situations and be appropriate for the facility's population. The facility as a minimum must be able to provide a suction machine, AED, and crash cart. (2-22-18)T

841. PHYSICAL FACILITY STANDARDS -- PROTECTION.
The facility must meet the provisions of NFPA Life Safety Code, as incorporated in Section 004 of these rules, applicable to facility. In addition, the following special requirements for the facility must be included: (2-22-18)T

01. **Manual Fire Alarm Pull Stations.** Manual fire alarm pull stations can be permitted to be locked, provided that staff is present within the area when it is occupied and staff has keys readily available to unlock the boxes. (2-22-18)T

02. **Alarm Notification.** Alarm notification (audible and visible) must be provided throughout the entire facility and must be ceiling-mounted. (2-22-18)T

03. **Fire Sprinkler Systems.** For the purpose of this rule, the facility must meet the provisions of NFPA Life Safety Code, as incorporated in Section 004 of these rules, as applicable to facility. (2-22-18)T

04. **Portable Fire Extinguishers.** For the purposes of this rule, the facility must meet the applicable provisions of NFPA Life Safety Code, as incorporated in Section 004 of these rules. In addition, the facility must meet the following special requirements: (2-22-18)T

a. Access to portable fire extinguishers must be locked and key must be with all staff members; (2-22-18)T

b. Portable fire extinguishers can be permitted to be located at staff locations and be provided locked and keyed; and (2-22-18)T

c. All staff members must be instructed in the proper use of portable fire extinguishers and other manual fire suppression equipment annually and new staff promptly upon commencement of duty. (2-22-18)T

05. **Generators.** The facility must ensure that the building generator is designed to meet the applicable codes in NFPA Life Safety code, Chapter 99, Health Care Facilities Code, and NFPA Standard # 110, Standard for Emergency and Standby Power Systems 2010 Edition, as incorporated in Section 004 of these rules, applicable to this facility. (2-22-18)T

842. PHYSICAL FACILITY STANDARDS -- INDIVIDUAL SLEEPING ROOMS AND ACCOMODATIONS REQUIREMENTS.
The facility must furnish and maintain in good repair accommodations for each person as incorporated in Section 004 of these rules, applicable to this facility. In addition, the facility must meet the following special requirements: (2-22-18)T

01. **Personal Rooms.** Personal sleeping rooms are not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes, and must have direct access to an exit corridor; (2-22-18)T

02. **Bed Requirements.** (2-22-18)T

a. Beds must have a mattress and be low-profile type so that it cannot be used by the person to reach the ceiling. (2-22-18)T

b. Beds must be a heavy-duty platform bed with rounded edges and bolted to the floor and must be of proper size and height for convenience of person; (2-22-18)T

c. Beds and bedding must be clean and appropriate to weather and climate; (2-22-18)T

d. Beds must not contain anchor points or floor guards that can be removed by persons and used as a weapon or for self-harm; (2-22-18)T

e. Pillows and mattresses must not have covers that can be easily removed by the person and used for suffocation; and (2-22-18)T

f. Beds must have nonelastic fitted sheets or a standard flat bed sheet. (2-22-18)T

03. **Closet Requirements.** Closets must contain racks, shelves accessible to persons, secured with tamper-resistant fasteners, and designed so they cannot be used as an anchor point. (2-22-18)T

04. **Activity Areas.** The facility must provide recreational space. (2-22-18)T

a. Equipment used by persons while supervised, such as computer equipment, and other facility equipment, must be located in rooms that can be locked when not in use. (2-22-18)T

b. Activity areas must be free of all protrusions, sharp corners, hardware, fixtures, or other devices. (2-22-18)T

05. **Outdoor Environment.** Security and safety for outdoor spaces used by persons are as follows: (2-22-18)T

a. A courtyard is preferred over fenced areas for aesthetic, privacy, and security reasons. If a fence is utilized, it is to be securely anchored at the bottom; (2-22-18)T

b. A minimum enclosure height of fourteen (14) feet (4.27 meters), if applicable; (2-22-18)T

c. Exits, service gates, or doors are to be strong enough to withstand force and are to be locked and alarmed; (2-22-18)T

d. Trees within the area must not facilitate climbing over a wall or fence; (2-22-18)T

e. Shrubs are to be small and low enough that a person cannot hide behind them; (2-22-18)T

f. Do not use rocks, gravel, dirt, and other planting bed or pathway materials that could be used as a weapon; (2-22-18)T

g. Outdoor furniture will either be anchored to concrete pads or too heavy to be moved and must be located to prevent escape; (2-22-18)T

h. All exposed fasteners in the courtyard area must receive tamper-resistant screws; and (2-22-18)T

i. Exterior light poles must be prohibited near the exterior perimeter of the enclosed yard or courtyard. (2-22-18)T

843. FIRE AND LIFE SAFETY STANDARDS -- EMERGENCY EGRESS AND RELOCATION.
Emergency egress and relocation standards must be maintained according to the code and mandatory references therein, incorporated in Section 004 of these rules. In addition, the facility must meet the following special requirements: (2-22-18)T

01. Exits. All exits must discharge into a fenced or walled courtyard, provided that not more than two (2) walls of the courtyard are the building walls from which egress is being made. (2-22-18)T

02. Enclosed Yards or Courtyards. Courtyards used for exit discharge must be of sufficient size to accommodate all occupants at a distance of not less than fifty (50) feet. (2-22-18)T

03. Furnishings, Decorations, or Other Objects. No items may be placed to obstruct exit access, exits, or exit discharge; (2-22-18)T

04. Access. Doors leading to the exterior must be permitted to be locked with key locks. The keys to unlock such doors must be maintained and available at the facility at all times, and the locks must be operable from the outside. (2-22-18)T

a. All keys necessary for unlocking doors installed in a means of egress must be individually identified by both touch and sound. (2-22-18)T

b. Where egress doors are locked with key-operated locks, doors and door hardware used for egress must be inspected monthly. (2-22-18)T

c. A manual release is required on both sides of the locked doors. (2-22-18)T

844. FIRE AND LIFE SAFETY STANDARDS -- OPERATING FEATURES.
Operating feature standards must be maintained according to the code and mandatory references therein, incorporated in Section 004 of these rules. In addition, the facility must meet the following special requirements: (2-22-18)T

01. Emergency Plans. The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters. (2-22-18)T

a. The written emergency plan for the facility must contain a diagram of the building showing emergency protection equipment, evacuation routes, exits, and assembly points. This diagram must be conspicuously posted in a common area within the facility. An outline of emergency instructions must be posted with the diagram. (2-22-18)T

b. A written fire safety plan must be provided provide for all of the following: (2-22-18)T

i. Use of alarms; (2-22-18)T

ii. Transmission of alarms to fire department; (2-22-18)T

iii. Emergency phone call to fire department; (2-22-18)T

iv. Response to alarms; (2-22-18)T

v. Isolation of fire; (2-22-18)T

vi. Evacuation of immediate area; (2-22-18)T

vii. Evacuation of smoke compartment (if applicable); (2-22-18)T

viii. Preparation of floors and building for evacuation; and (2-22-18)T

ix. Extinguishment of fire. (2-22-18)T

c. The facility must periodically review the written emergency plan and thoroughly test it to ensure rapid and efficient function of the plan. (2-22-18)T

d. The facility must hold unannounced evacuation drills at least quarterly for each shift of personnel for a total of no less than twelve (12) per year. The evacuation drills must be irregularly scheduled throughout all shifts and under varied conditions. The facility must actually evacuate persons into the secured courtyard or secured fenced area during at least one (1) drill each shift for each month. (2-22-18)T

e. The facility must document evacuation drills, cite the problems investigated, and take the appropriate corrective action for the identified problems. (2-22-18)T

02. Report of Fire. The facility must submit to the Department's Division of Licensing and Certification a separate report of each fire incident that occurs within the facility within ten (10) days of the occurrence. The facility must use the Department's Division of Licensing and Certification's reporting form, "Facility Fire Incident Report," available online at: http://www.facilitystandards.idaho.gov. The facility must provide all specific data concerning the fire including the date, origin, extent of damage, method of extinguishment, and injuries, if any, for each fire incident. A reportable fire incident is when the facility has an incident that: (2-22-18)T

a. Causes staff to activate the facility emergency plan in whole or in part; (2-22-18)T

b. Causes an alarm throughout, causing staff or persons to activate the facility emergency plan, in whole, or in part; (2-22-18)T

c. Causes a response by the fire department or emergency services to investigate an alarm or incident; (2-22-18)T

d. Is unplanned in which persons are evacuated, prepared to evacuate, partially evacuated, or protected in place, due to smoke, fire, unknown gases/odors, or other emergency; or (2-22-18)T

e. Results in an injury, burn, smoke inhalation, death, or other fire or emergency related incident. (2-22-18)T

03. Fire Watch. The facility must institute a fire watch during any time the fire alarm, smoke detection system is inoperable for greater than four (4) hours in a twenty-four (24) hour period, or during any time the fire sprinkler system is out of service for more than ten (10) hours in a twenty-four (24) hour period, or both. (2-22-18)T

04. Smoking Regulations. Facility policies and procedures must include whether smoking is allowed in the facility. If the facility policy allows smoking, smoking regulations must be adopted and must include the following provisions: (2-22-18)T

a. Smoking must be prohibited in any room, ward, or individual enclosed space where flammable

liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas must be posted with signs that read "NO SMOKING" or must be posted with the international symbol for no smoking. (2-22-18)T

b. Smoking by persons classified as not responsible must be under direct supervision of a staff member. (2-22-18)T

c. Ashtrays of noncombustible material and safe design must be provided in all areas where smoking is permitted. (2-22-18)T

d. Metal containers with self-closing cover devices into which ashtrays can be emptied must be readily available to all areas where smoking is permitted. (2-22-18)T

845. -- 859. (RESERVED)

860. VEHICLES.
The facility must develop, implement, monitor, and maintain a written vehicle safety policy for each vehicle owned, leased, or used. The facility must have vehicle safety equipment, policies, and staffing requirements that meet the following requirements: (2-22-18)T

01. **Preventative Maintenance Program**. The establishment of a preventative maintenance program for each vehicle; (2-22-18)T

02 **Vehicle Inspections**. Vehicle inspections and other regular maintenance needed to ensure person's safety; (2-22-18)T

03 **Accessory Inspections**. Inspection of wheelchair lifts, securing devices, and other devices necessary to ensure person's safety. (2-22-18)T

04. **Fire Extinguishers, Maintenance, and Inspections**. Vehicle mounted fire extinguishers must be inspected when initially placed in service and in thirty (30) day intervals, and must be subject to maintenance at intervals of not more than one (1) year. (2-22-18)T

05. **Staff Requirement**. There must be two (2) staff members assigned for transport of each person; and (2-22-18)T

06. **Driver**. One (1) driver. (2-22-18)T

861. -- 869. (RESERVED)

870. INFECTION CONTROL.
The facility must provide a sanitary environment to avoid sources and transmission of infections. The facility must provide the following: (2-22-18)T

01. **Active Program Requirement**. Develop, implement, and monitor an active program for the prevention, control, and investigation of infection and communicable diseases; (2-22-18)T

02. **Implement Corrective Action**. Implement successful corrective action in affected problem areas; (2-22-18)T

03. **Record of Incidents and Corrective Action**. Maintain a record of incidents and corrective actions related to infections; (2-22-18)T

04. **Employee with Signs of Illness**. Prohibit employees with symptoms or signs of a communicable disease from direct contact with persons and their food; and (2-22-18)T

05. **Reportable Diseases**. Report diseases as required according to state law. (2-22-18)T

871. -- 899. (RESERVED)

900. STANDARD OF LICENSURE: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT.
The facility must develop, implement, and maintain an ongoing and data-driven Quality Assessment and Performance Improvement (QAPI) program. (2-22-18)T

901. PROGRAM SCOPE AND DATA COLLECTION.
The program must be ongoing and demonstrate measurable improvement in person outcomes and safety by using quality indicators or performance measures. (2-22-18)T

01. **Data Collection**. The facility must collect quality indicator data in sufficient form and frequency to determine the quality of services and identify opportunities for improvement. Quality indicators must include: (2-22-18)T

a. Quality of services provided directly and under agreement including an adherence to trauma informed care principals and person centered care principals; (2-22-18)T

b. Incidents and accidents; (2-22-18)T

c. Grievances; (2-22-18)T

d. Allegations of abuse, neglect, and mistreatment; (2-22-18)T

e. Physical restraint use, including emergency use; (2-22-18)T

f. Medication to manage mental health or inappropriate behavioral use, including emergency chemical restraints and as needed medications; and (2-22-18)T

g. Areas identified by the facility as high-risk, high-volume, or problem-prone based on the prevalence and severity of incidents and negative impacts to person safety and quality of care. (2-22-18)T

02. **Establish Measurable Goals**. The facility must establish measurable goals for all quality indicators that are being tracked. (2-22-18)T

902. PROGRAM DATA ANALYSIS.
Quality indicator data must be regularly analyzed to: (2-22-18)T

01. **Monitor Effectiveness and Safety**. Monitor the effectiveness and safety of the facility's services and quality of care; and (2-22-18)T

02. **Identify Opportunities**. Identify opportunities that could lead to improvements and changes in person care that include those areas that are not meeting established goals. (2-22-18)T

903. IMPLEMENTING AND MONITORING CHANGES MADE AS A RESULT OF DATA ANALYSIS.
Based on the data analysis, the facility must: (2-22-18)T

01. **Develop Changes.** Develop and implement changes in areas identified in need of improvement (2-22-18)T

02. **Monitor to Ensure that Changes were Effective**. Monitor to ensure the changes were effective in achieving established goals; and (2-22-18)T

03. **Monitor to Ensure Changes are Sustained.** Monitor to ensure that improvements are sustained over time. (2-22-18)T

904. **PERFORMANCE IMPROVEMENT PROJECTS.**
A distinct improvement project must be conducted annually. The facility must document: (2-22-18)T

01. **The Projects.** The project(s) that are being conducted; (2-22-18)T

02. **The Reasons.** The reason(s) for implementing the project; and (2-22-18)T

03. **Description.** A description of the project's results. (2-22-18)T

905. -- 999. **(RESERVED)**

Negotiated Rulemaking Meeting and Comment Summary

Wednesday, January 24, 2018 – 1:30 p.m. (MST)

Negotiated Rulemaking DOCKET NO. 16-0315-1801

In-Person meeting held in Boise with telephone conference access, as published in the January 3, 2018 Administrative Bulletin (see attached attendee lists)

Facilitator: Tamara Prisock, Administrator, Division of Licensing and Certification
Bureau: Facility Standards, Division of Licensing and Certification

Call to Order and Outline Meeting Format

I. Purpose of Meeting
a. Introduction to what rules are being proposed

II. Discussion Points
a. Outline the points that will be discussed

III. Follow Up
a. Written comments for Docket No. 16-0315-1801 are to be submitted on or before January 31, 2018, to:

Tamara Prisock DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5564; Fax: (208) 334-6558
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Negotiated Rulemaking - Comment Summary
DOCKET NO. 16-0315-1801

1. **Verbal Comments from January 24, 2018;**
2. **Written Comments Submitted Post-Meeting until January 31, 2018; and**
3. **Responses**

Verbal and written comments were submitted by the following individuals/organizations:

W- Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Entire Chapter			
Comment from: Idaho State Independent Living Council			
V, W	Department representatives agreed that trauma informed care and person centered planning principles would be required by the licensing rules. The proposed rules published on January 3, 2018, do not include these principles.	DHW Response: The intent is for the facility to provide care and services using trauma-informed care principles as well as person-centered planning. Definition of trauma-informed care added to definitions. Training requirements in section 204.02 revised to add requirement that professional program staff receive training in trauma-informed care and in person-centered planning. The person's right to participate in treatment added to section 304.	
Comment from: Josie Murray			
V	I just wanted to make sure that that's what we were saying because I know that we are using restraints later, but then I	DHW Response:	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	wanted to make sure that we were not going to withhold any food or hydration or anything like that.	Definition of abuse revised to include punishment. Withholding food or water is included in the definition of punishment, and punishment is considered abuse.	
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council recommends the facility meet already established JCAHO behavioral health standards of treatment rather than creating a new license and navigating the unchartered water of a whole new facility type.	DHW Response: The department's Division of Licensing and Certification will license and oversee the secure treatment facility.	HB 222, passed during the 2017 Legislative Session, states the license and survey process will be developed by the Department's Division of Licensing and Certification.
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council strongly encourages an emphasis on thorough training of the surveyors selected to conduct the assessments of the secure treatment facility. Training should include an understanding of adults with a dual diagnosis and best practice in serving this specific population. A recommendation the Council would make is for future surveyors' involvement in educational opportunities provided through the National Association for Persons with Developmental Disabilities and Mental Health Needs.	DHW Response: Although this comment is not directed at a specific section of the rule chapter, the suggestion is a good one, and the division will explore the educational resources suggested for surveyors.	
Comment from: Idaho Council on Developmental Disabilities			
V, W	A specific recommendation made by the Council during negotiations for House Bill 222 was that the statute include a definition of trauma informed care. The Council desired seeing language provided within the statute that would	DHW Response: Definition of trauma-informed care added to definitions.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	clarify how an individual's trauma history would be collected. This assessment would take into consideration previous restraint use, seclusion or isolation used in a punitive way, all contributing to useful information for the purpose of treatment planning and in specific de-escalation strategies to avoid re-traumatizing the individual During the negotiations, the Council was informed that recommendations regarding trauma informed care approach would be better served within the rules vs. the statute. With this assurance, the Council withdrew its objections to the lack of this specific language in the statue. The Council requests that a specific section be added to the rules that details the definition, trauma history, and treatment planning be addressed with specificity. The Council recommends the following for development of this section rule: 1) http://thenadd.org/trauma-informed-toolkit/ 2) http://thenadd.org/news/trauma-informed-therapeutic-supports-training/ 3) http://trauma.jbsinternational.com/traumatool/Module4.html 4) http://trauma.jbsinternational.com/traumatool/Module5.html#IssueBrief 5) Screening and Assessment http://trauma.jbsinternational.com/traumatool/Module1.html.	Training requirements in section 204.02 revised to add requirement that professional program staff receive training in trauma-informed care and in person-centered planning. Subsection added to Section 402 to include requirements for comprehensive trauma history and de-escalation strategy information, and an assessment of individual needs and strengths. Added language to section 502 to require policies and procedures align with trauma-informed care and person-centered planning principles.	
Comment from: DisAbility Rights Idaho			
V, W	During negotiations with Department representatives over the House bill which eventually became Idaho Code Title 56 Chapter 14, disability advocacy groups asked for the statute to incorporate trauma informed care principles into the bill. In exchange for withdrawing our objections to the bill, the	DHW Response: Definition of trauma-informed care added to definitions. Training requirements in section	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	department representatives agreed that trauma informed care principle would be required by the licensing rules. These rules do not reflect that agreement.	204.02 revised to add requirement that professional program staff receive training in trauma-informed care and in person-centered planning. Subsection added to Section 402 to include requirements for comprehensive trauma history and de-escalation strategy information, and an assessment of individual needs and strengths. Added language to section 502 to require policies and procedures align with trauma-informed care and person-centered planning principles.	
Rule 16.03.15.001.02			
Comment from: Idaho State Independent Living Council			
V, W	The language of this section must incorporate all of the provisions within Idaho Code 66-1404. Further, it must also clarity that these rules provide for creation of only one facility, as granted under Idaho 66-1402.	DHW Response: Since statute overrides rules, it is generally not advised to restate statute in administrative rules. This rule chapter aligns with Chapter 14, Title 66, Idaho Code. Further, 66-1402, Idaho Code grants only the Department the power to establish a secure treatment facility.	
Comment from: ACLU of Idaho			

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
V, W	It must be clearly stated that these rules only allow for the creation of <u>one</u> facility per the authority granted under Idaho Code 66-1402. To ensure that only individuals who meet <u>all</u> the admission criteria under Idaho Code 66-1404, we recommend making explicit reference to the following statutory requirements: a. That an individual has a developmental disability as determined by the DHW; b. That the individual be an adult; c. That the individual meet one of the following items: i. The individual is being criminally adjudicated and is undergoing evaluation for competency to stand trial in accordance with Idaho Code chapter 2, title 18; ii. The individual is being criminally adjudicated and is committed to the DHW for treatment to restore their competency in accordance with Idaho Code chapter 2, title 18; iii. The individual is civilly committed to the custody of DHW in accordance with Idaho Code chapter 4, title 66; d. That the individual presents a substantial threat to the safety of others and that a judicial finding has ordered that the individual may be confined to the secure treatment facility.	DHW Response: Since statute overrides rules, it is generally not advised to restate statute in administrative rules. This rule chapter aligns with Chapter 14, Title 66, Idaho Code. Further, 66-1402, Idaho Code grants only the Department the power to establish a secure treatment facility.	
Comment from: DisAbility Rights Idaho			
V, W	The language of this section appears to reference some of the admission criteria of Idaho Code 66-1404. This section should incorporate <u>all</u> of the provisions of Idaho Code 66-1404. It also must be made clear that these rules only allow	DHW Response: Since statute overrides rules, it is generally not advised to restate statute in administrative rules. This rule chapter aligns with	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	for the creation of one facility per the authority granted under Idaho 66-1402.	Chapter 14, Title 66, Idaho Code. Further, 66-1402, Idaho Code grants only the Department the power to establish a secure treatment facility.	
Comment from: DisAbility Rights Idaho			
V, W	This section must reference all four (4) mandatory admission criteria as listed in Idaho Code 66-1404.	DHW Response: Since statute overrides rules, it is generally not advised to restate statute in administrative rules. This rule chapter aligns with Chapter 14, Title 66, Idaho Code.	
Comment from: DisAbility Rights Idaho			
V, W	Idaho Code 66-1402(1) authorized the creation of a single secure facility, however, throughout the proposed rules it appears that more than one secure facility is possible. For example, proposed rule .030.02 refers to "each license," .830 refers to "each secured facility," .831.01.b refers to "each facility," and .831.04 refers to "each facility."	DHW Response: This rule chapter aligns with Chapter 14, Title 66, Idaho Code. 66-1402, Idaho Code clearly grants only the Department the power to establish a secure treatment facility.	
Rule 16.03.15.010			
Comment from: Idaho State Independent Living Council			
V, W	The definition of "physical abuse" does not include the use of excessive force when applying restraint, including mechanical restraint, nor does it include the use of inappropriate restraint, such as prone restraint, and include chemical restraint or restraint devices that are not compliant	DHW Response: Definition added, incorporating suggested language.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	with state and Federal laws and regulations.		
	The definition of "Sexual Abuse" appears to imply that vulnerable clients can give consent for sexual relations. By definition: the means to be admitted to the facility, indicates that residents of the facility are vulnerable adults under court order, and therefore, unable to give consent. Further, the rule seems to imply that if a resident doesn't attempt to defend themselves, consent is granted. We suggest that the Department revisit the definition of sexual abuse with consideration of the above.	Definition added, incorporating suggested language.	
	Missing definition: Active treatment – Given issues at similarly situated state institutions, the omission is glaring. We suggest defining and implementing Active Treatment.	Although "active treatment" is not defined, Section 304 was revised to add that the client has the right to participate in the development of the treatment plan.	
	The definition of "Available staff" is unclear. My understanding is that this is a stand-alone facility. From where will the "available staff" come? We recommend that the Department clarify for where the "available staff" will come; that they not come directly from SWITC which is directly adjacent to the facility.	Definition of "Sufficient staff" added. Minimum staffing ratios added to section 201.	
	The definition of "Chemical restraint" should mirror the definition found in 42 C.F.R. 482.13(e)(1)(B), which defines such a restraint as a "drug or medication when it is used as a restriction to manage the patient's behavior or restrict the	Definition added, incorporating suggested language.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	patient's freedom of movement and is not a standard treatment or dosage for the patient's condition."		
	The definition of "client" is inconsistent with Idaho Code §66-1403(8) and dehumanizing. The term "person" is accepted use within the Idaho statutes and the field. We recommend the usage of "person."	Rule chapter revised to use the term "person" rather than "client."	
	The definition of "Individual Treatment Plan (ITP)" should include programs and strategies that are effective in ameliorating the behaviors that lead to placement in the secure treatment facility. It doesn't specify teaching independent living and self-management alternative plans such as a Plan A, B, C and so forth. All people involved, including the individual, should know what plan B, C and D are prior to a need to move on from Plan A when it isn't working.	Definition added, incorporating suggested language.	
	The definition of "Interdisciplinary Team (IDT)" does not include the individual and their Guardian. You reference above and under, "The desired outcome the client is trying to achieve." How do you know what person wants to achieve, if you haven't included them as part of the team and in development of the plan? We recommend clearly identifying the person and their Guardian as part of the IDT.We suggest in both definitions above (ITP & IDT), include the person with the use of ICF/ID IDAPA language.	Definition added, incorporating suggested language.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	The definition of "Legal Guardian" is vague and appears to broaden the definition of Guardian beyond Idaho Code 66-404. We oppose broadening the definition of guardian.	Definition revised, incorporating suggested language.	
	The definition of "Neglect" doesn't include failure to implement, monitor and appropriately update the Individual Treatment Plan. The issue is of significant concern given recent events in the SWITC facility and findings located in the July 19, 2017 complaint survey conducted by the Division of Licensing & Certification.	Current definition adequately covers what will be considered to be neglect.	Not all situations in which the facility fails to implement, monitor or update treatment plans constitutes neglect.
	The definition of "Reportable Incident" does not include the requirement that the facility report allegations of staff abuse or neglect of residents to the Bureau of Facility Standards. All incidents within this definition should be reported to BFS.	Definition revised to include allegations of staff abuse and neglect.	
	Trauma Informed Care is not defined. Define, train facility staff and implement Trauma Informed Care. Given that this is a behavior health care facility, we suggest defining and implementation based on 4.0 Trauma-Informed Care for Behavioral Health Manual, and of course, SAMHSA guidelines and principles.	Definition added, incorporating suggested language.	
	Person Centered Planning is not defined. Define, train facility staff and implement Person Centered Planning as defined in both the developmental disabilities and behavioral health programs.	Definition of "Person-centered care" added.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	The definition of "Sufficient Staff" should make it explicitly clear that the facility will be staffed 24/7 with its own well qualified and trained staff, no staff from the nearby facility, as required by CMS regulations.	This facility is state-licensed only and not subject to CMS regulations. Since there may be long periods of time in which the facility has no residents, it is not operationally feasible to staff the facility 24/7 with its own staff.	
Comment from: ACLU of Idaho			
V, W	We offer the following recommendations to more appropriately and clearly define "Sexual Abuse" and "Client." a. The definition of "Sexual Abuse" should prohibit sexual activity between clients and staff in circumstances where the client may have given "affirmative permission." Further clarification should also be provided regarding the definition of sexual abuse when the client is unable to defend themselves as it could currently be interpreted to mean that if a client can defend themselves, then sexual abuse could not have occurred. Finally, we also recommend that rape be specifically included in this definition. b. The definition of "Client" needs to align with the term "person" as defined in Idaho Code §66-1403(8). We recommend making specific reference to this definition to ensure that all clients of the secure treatment facility have been subject to a judicial proceeding, which has authorized their admission to the secure treatment facility.	DHW Response: Definition added for sexual abuse. Entire chapter revised to use the term "person" rather than "client."	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Physical Abuse" does not appear to incorporate the use of excessive force when placing an individual in restraints, nor does it include the use of inappropriate or non-approved restraints or the use of	DHW Response: Definition added, incorporating suggested language.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	physical or chemical restraints which are not in compliance with Federal and State laws and regulations. The definition of "Sexual Abuse" does not appear to prohibit sexual activity between clients and staff in circumstances where the client may have given "affirmative permission." It also appears to only prohibit sexual assault against clients when the client is unable to defend themselves. This could be interpreted to mean that if a client can defend themselves, then sexual abuse could not have occurred. Additionally, although sexual assault is specifically mentioned in the definition of sexual abuse, rape is not. There is no scenario where licensing should approve or allow sexual contact between staff and a resident or two residents at the secure facility. The definition of sexual abuse should require a zero tolerance for sexual activity between staff and residents or between residents.	Definition added for sexual abuse. Definition revised to include all sexual activities.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Available Staff" needs to clarify that "on the premises" specifically means on the secure treatment facility premises, so as not to imply that "available staff" includes those at nearby facilities which are supposed to be separate and distinct from the secure treatment facility.	DHW Response: Definition of "Sufficient staff" added. Minimum staffing ratios added to section 201. Since there may be long periods of time in which the facility has no residents, it is not operationally feasible to staff the facility 24/7 with its own staff.	
Comment from: DisAbility Rights Idaho			

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
V, W	The definition "Chemical Restraint" needs to mirror the definition found in 42 C.F.R. 482.13(e)(1)(i)(B), which defines such a restraint as a "drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition."	DHW Response: Definition added, incorporating suggested language.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Client" needs to align with the term "person" as defined in Idaho Code §66-1403(8), which is defined as "an individual subject to judicial proceedings authorized by the provisions of..." Idaho Title 66, Chapter 14 who has been admitted and dispositioned into the secure treatment facility pursuant to Idaho Code §66-1404.	DHW Response: Entire chapter revised to use the term "person" rather than "client."	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Client Advocate" should include a prohibition on decision-making by the Advocate for or on behalf of the client. There is no legal basis for anyone other than a legal guardian or an individual with a previously executed power of attorney or advance directive to make decisions for or on behalf of another person.	DHW Response: Definition added, incorporating suggested language.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Individual Treatment Plan (ITP)" does not reference that it must include programs which include strategies that are effective in ameliorating the behaviors which resulted in the admission to the secure treatment facility and the teaching of self-management strategies to promote discharge to a less restrictive living environment. It also does not include the prevention or deceleration of regression or loss of current optimal functional status.	DHW Response: Definition added, incorporating suggested language.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Interdisciplinary Team (IDT)" does not include the individual client themselves and their guardian as is required under the definition of this term in the ICF/ID IDAPAs, specifically 13.03.11.101.16.	DHW Response: Definition added, incorporating suggested language.	
Comment from: DisAbility Rights Idaho			
V, W	Isolation is an undefined term used in Idaho Code 66-412(2) which reads: "A developmentally disabled person shall not be put in isolation." Idaho Code 66-1406 Rights of Persons in the Secure Treatment Facility guarantees that a person in the secure facility "shall" have all the civil rights provided for in chapter 4, title 66, Idaho Code except that the secure facility can limit a person's right to communicate, visit with people, and have access to their property. The prohibition from isolation has not been limited.	DHW Response: Definitions of "isolation" and "seclusion" revised to be used interchangeably. Section.501 revised to prohibit the use of seclusion.	
Comment from: DisAbility Rights Idaho			
V, W	Licensing has proposed to define isolation as: "The involuntary confinement of a client alone in a room or area from which the client is physically prevented from leaving that is separate from others, without staff contact or monitoring." Licensing has proposed to define seclusion as: "The involuntary confinement of a client alone in a room or area from which the client is physically prevented from leaving that includes continuous in-person staff monitoring." Pursuant to the proposed rules, the only difference between	DHW Response: Definitions revised to give "isolation" and "seclusion" the same definition.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	isolation and seclusion is whether a staff person monitors the person while the person is in isolation.		
Rule 16.03.15.011			
Comment from: Denise Myler			
W	It would be my strongest recommendation that the staff ratio be 5:1. It would also be my strongest recommendation that the professional staff, physical therapists, psychologists, etc., be at least 10:1. The staff in the facility should be strictly for the facility and not overseeing from any adjacent facility.	DHW Response: Since there may be long periods of time in which the facility has no residents, it is not operationally feasible to staff the facility 24/7 with its own staff.	
Comment from: ACLU of Idaho			
V, W	We recommend defining "Punishment" to include withholding "medical care or treatment" which can be used as a means to discipline or penalize a client for the purpose of controlling behavior.	DHW Response: A definition of "punishment" was added under the definition of "abuse," incorporating the suggested language.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Legal Guardian" is too broad and appears to encompass individuals beyond the guardianship provisions found under Idaho Code 15-5-301, et seq., or Idaho Code 66-404. The term guardian is a legal term of art and is specifically defined in the previously mentioned statutory sections. Any "court-appointed surrogate" designated to advocate on behalf of a client that was not appointed as a guardian pursuant to Idaho Code 15-5-301, et seq., or Idaho Code 66-404 is not a "Guardian."	DHW Response: Definition revised, incorporating suggested language.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Neglect" does not include a staff's failure to properly implement a client's Individual Treatment Plan (ITP) or programs.	DHW Response: Current definition adequately covers what will be considered to be neglect.	Not all situations in which the facility fails to implement, monitor or update treatment plans constitutes neglect.
Comment from: DisAbility Rights Idaho			
V, W	There is no definition of the term "Restrictive Intervention" although the term is used throughout these rules.	DHW Response: Definition added.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Physical Restraint" only applies to holds, devices, materials, or equipment that the client "cannot remove easily." The phrase "cannot remove easily" is currently being removed from the definition of this term in the proposed amendments to the Residential Habilitation administrative rules and should be removed from this definition as well.	DHW Response: The current definition of physical restraint is appropriate for this facility.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Punishment" does not include withholding "medical care or treatment" as a means to discipline or penalize a client for the purpose of controlling behavior.	DHW Response: Definition revised, incorporating suggestion.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of abuse includes a prohibition of "corporal" punishment. This term is undefined. Further, the use of the proposed defined act of "punishment" is not included in the definition of abuse.	DHW Response: Definition added. Reference to "corporal punishment" removed.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Reportable Incident" notably omits the requirement that a facility report allegations of staff abuse, neglect, or mistreatment of clients to Licensing and Certification, including no requirements to report incidents of sexual assault.	DHW Response: The definition of "reportable incident" does include allegations of staff abuse, neglect, or mistreatment of persons.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Seclusion" does not align with the prohibition of isolation of an individual with a developmental disability pursuant to Idaho Code 66-412, a statute that is applicable to this secure treatment facility.	DHW Response: Definitions of "isolation" and "seclusion" revised to be used interchangeably. Section.501 revised to prohibit the use of seclusion.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Sufficient Staff" needs to make explicitly clear that such staff be present on the secure treatment facility grounds, on-duty, and awake on a 24-hour basis as is required per CMS regulations for ICF/IDs.	DHW Response: Since there may be long periods of time in which the facility has no residents, it is not operationally feasible to staff the facility 24/7 with its own staff.	
Comment from: DisAbility Rights Idaho			
V, W	The definition of "Time Out" in these rules does not require constant visual supervision by staff, does not prohibit a client's residential unit from being used as a "designated area," nor does it state that such "designated area" be free from hazardous conditions including, but not limited to, the presence of sharp corners, objects, uncovered light fixtures,	DHW Response: Section 502.02 revised to include these suggestions.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	unprotected electrical outlets, etc. Furthermore, there does not appear to be any restrictions or safeguards in place for the use of timeouts as found in 42 C.F.R. 483.450(c), such as constant staff supervision or documentation or recordkeeping requirements of timeout activities.		
Comment from: DisAbility Rights Idaho			
V, W	The behavior intervention plan that incorporates the use of timeout must (a) be derived from a behavioral assessment, (b) incorporate reinforcement strategies for appropriate behavior, (c) be of brief duration, (d) be evaluated by objective outcome data, and (e) be consistent with the scientific literature and current best practices.	DHW Response: Section 502.02 revised to include these suggestions.	
Rule 16.03.15.020			
Comment from: Idaho State Independent Living Council			
V, W	In current form, the proposed rules and requirements for licensure do not explicitly state that only one, four bed secure treatment facility as per Idaho Code Title 66, Chapter 14 will be licensed. We ask that you are specific; that only one facility will be licensed under these rules.	DHW Response: This rule chapter aligns with Chapter 14, Title 66, Idaho Code. 66-1402, Idaho Code clearly grants only the Department the power to establish a secure treatment facility.	
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council recommends providing clarification on the general requirements for licensure, which do not read that the license is specific to one secure treatment facility.	DHW Response: This rule chapter aligns with Chapter 14, Title 66, Idaho Code. 66-1402, Idaho Code clearly grants only the Department the power to	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
		establish a secure treatment facility.	
Comment from: ACLU of Idaho			
V, W	As we stated in 001.02 – Scope, we once again request that the general requirements for licensure explicitly state that only one facility is allowed to be licensed per the authority granted under Idaho Code 66-1402.	DHW Response: This rule chapter aligns with Chapter 14, Title 66, Idaho Code. 66-1402, Idaho Code clearly grants only the Department the power to establish a secure treatment facility.	
Comment from: DisAbility Rights Idaho			
V, W	The general requirements for licensure do not explicitly state that only one facility is allowed to be licensed as the secure treatment facility pursuant to Idaho Code Title 66, Chapter 14.	DHW Response: This rule chapter aligns with Chapter 14, Title 66, Idaho Code. 66-1402, Idaho Code clearly grants only the Department the power to establish a secure treatment facility.	
Rule 16.03.15.051(c)			
Comment from: Idaho State Independent Living Council			
V, W	Complaints of immediate jeopardy should require an investigation survey within twenty-four hours or one business day after the allegation is reported. Complaints not alleging immediate jeopardy should result in an	DHW Response: Section .041 revised to require complaints alleging immediate jeopardy be investigated within 1 business day, and complaints not	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	investigation survey in no more than five business days after the allegation is reported.	alleging immediate jeopardy be investigated within five business days.	
	Additionally, we have concerns that both Licensing and Certification and SWITC are both within the Idaho Department of Health and Welfare and answer to the same director. We don't question the integrity of the people involved. However, we do question the integrity of the process, especially in light of recent events at SWITC.	Chapter 14, Section 66 Idaho Code states that the Department's Division of Licensing and Certification will develop a license and survey process for the facility.	
Comment from: ACLU of Idaho			
V, W	Considering the recent news of abuse and neglect at the Southwest Idaho Treatment Center, we believe the response times indicated in this section are entirely too broad and will continue to perpetuate ongoing harm faced by patients who are in need of immediate care. Instead, we recommend that complaints of immediate jeopardy should result in an investigation survey within twenty-four (24) hours or one (1) business day after the allegation is reported. Complaints no alleging immediate jeopardy should result in an investigation survey in no more than five (5) business days after the allegation is reported.	DHW Response: Section .041 revised to require complaints alleging immediate jeopardy be investigated within 1 business day, and complaints not alleging immediate jeopardy be investigated within five business days.	
Comment from: DisAbility Rights Idaho			
V, W	Complaints of immediate jeopardy should render an investigation survey within twenty-four (24) hours or one (1) business day after the allegation is reported. Complaints not	DHW Response: Section .041 revised to require complaints alleging immediate	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	alleging immediate jeopardy should render an investigation survey in no more than five (5) business days after the allegation is reported.	jeopardy be investigated within 1 business day, and complaints not alleging immediate jeopardy be investigated within five business days.	
Rule 16.03.15.073			
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council recommends providing a clearly detailed plan to address the safety and emergency plan to be implemented should licensure suspension occur.	DHW Response: Section 441 revised to clarify requirements. The details of a facility emergency plan will be included in the facility's policies and procedures.	
Comment from: DisAbility Rights Idaho			
V, W	This provision does not contain any information on what happens to clients immediately upon a summary suspension including, but not limited to, what safeguards are immediately put in place to ensure that whatever "emergency" that constituted the suspension is immediately redressed, clients are immediately transported to other appropriate placements, etc.	DHW Response: Section 441 revised to clarify requirements. The details of a facility emergency plan will be included in the facility's policies and procedures.	
Rule 16.03.15.100			
Comment from: DisAbility Rights Idaho			
V, W	There needs to be specific, detailed, and rigorous qualification education and experience requirements as to	DHW Response:	The administrator of the facility is not a clinical

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	whom can be chosen as the administrator for this facility. Please also see our comments to 16.03.15.110.01.	The requirements contained in section .110 provide the appropriate requirements.	position; rather, it is a management position.
Rule 16.03.15.102			
Comment from: DisAbility Rights Idaho			
V, W	The rule allows for either the client or their guardian or advocate to be informed as to whom to contact for grievances. This creates the possibility for situations where a client may have a grievance but no knowledge as to whom the grievance should be communicated if this information is only shared with their guardian or advocate.	DHW Response: Section 102 states the facility must inform each person AND legal guardian AND advocate.	
Rule 16.03.15.103			
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council recommends the inclusion of rules that address a detailed training plan required for all newly hired direct care staff. Rules should also address the priorities of a detailed plan for continuous education to build on the various skill sets required of the direct care workforce.	DHW Response: Section 204.02 have been revised to more clearly state the requirements. The requirements include ongoing training, education, and demonstrated knowledge.	
	The Council recommends that information in plain language and/or an infographic be provided to each individual served within the secure treatment facility as to who and how a resident reports abuse, neglect, or mistreatment.	Section 302.01 covers this requirement. The suggestion about plain language and/or an infographic will be considered for use in the facility.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: DisAbility Rights Idaho			
V, W	There does not appear to be a specific requirement that the facility immediately train staff on such policies and procedures immediately upon hiring and then continuously retrain staff on such policies and procedures on at least an annual basis to ensure that all staff are aware of their responsibilities under these policies. Considering the highly published issues related to the recent, widespread staff abuse and neglect at the State run ICF/ID, it seems prudent that such requirements be explicitly made a part of any licensing rules pertaining to the secure treatment facility.	DHW Response: Section 204.02 have been revised to more clearly state the requirements. The requirements include ongoing training, education, and demonstrated knowledge.	
Comment from: DisAbility Rights Idaho			
V, W	There also does not appear to be a requirement that the facility immediately inform each client and their guardian or advocate, where applicable, as to these policies and procedures immediately upon admission to the facility so that clients and their guardians and advocates can be informed as to what constitutes abuse, neglect, and mistreatment and to whom reports of any suspected abuse, neglect, or mistreatment should be made.	DHW Response: Section 302 revised to incorporate this suggestion.	
Rule 16.03.15.110.01			
Comment from: Denise Myler			
W	A staff person for this position should be at least 21 is, for me, too young and inexperienced. The Department needs to move the age to be at least 30 years old and include a degree with a minimum of 3-5 years of work experience.	DHW Response: The requirements contained in section .110 provide the appropriate requirements.	The administrator of the facility is not a clinical position; rather, it is a management position.

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: ACLU of Idaho			
V, W	These administrator requirements appear to be very minimal and fail to include any requirement they have experience working with individuals with severe mental illness, as should be required given that the facility will house individuals with a dual diagnosis of intellectual disability and severe mental illness. The requirements also fail to include any provision that the administrator have no previous incidents of abuse, mistreatment, or neglect on their employment record.	DHW Response: The requirements contained in section .110 provide the appropriate requirements.	The administrator of the facility is not a clinical position; rather, it is a management position.
Comment from: DisAbility Rights Idaho			
V, W	There needs to be specific, detailed, and rigorous qualification education and experience requirements as to whom can be chosen as the administrator for this facility. There is also no requirement listed that the administrator not have any substantiated indents of abuse, neglect, exploitation, or mistreatment in their employment or criminal history. There is also no requirement that the administrator have any experience providing care or services to people with intellectual or developmental disabilities who also have a diagnosis of serious mental illness, even though those are the only individuals who can be placed in this facility. Further, a facility administrator should have some previous management experience, especially in dealing with those who have violent backgrounds.	DHW Response: The requirements contained in section .110 provide the appropriate requirements. The administrator must clear a criminal history background check.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.110.02			
Comment from: Idaho State Independent Living Council			
V, W	The requirement for the administrator are minimal and fail to include that the administrator is experienced in working with people who have co-occurring ID/DD and severe mental illness. The requirements do not include provisions that the administrator have no previous incidents of abuse, mistreatment or neglect on their employment record.	DHW Response: The requirements contained in section .110 provide the appropriate requirements. The administrator must clear a criminal history background check.	
Comment from: DisAbility Rights Idaho			
V, W	As to subsection (b.), the allowance of one (1) business day to notify Licensing and Certification of any "anticipated or actual termination of any service vital to the continued safe operation of the secure facility of health, safety, and welfare of its clients and personnel" is entirely too generous of a time period considering that termination of such a service may result in immediate jeopardy.	DHW Response: The Department feels that one business day is a reasonable standard.	
Comment from: DisAbility Rights Idaho			
V, W	As to subsection (c.), the allowance of two (2) business days to notify Licensing and Certification of all "reportable incidents" is also too generous, again, considering that such an incident may be the death of a client. Additionally, it is interesting to note that the reporting requirements for the administrator of the secure treatment facility are less strict than the reporting requirements of a community setting provider, such as a certified home provider.	DHW Response: Subsection (c.) requires these incidents be reported within one business day.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.201			
Comment from: DisAbility Rights Idaho			
V, W	There should also be a requirement that all staff be trained prior to the facility operating under its license, to ensure that all of the staff who are on-duty are adequately trained prior to working with clients.	DHW Response: Section .200 requires the facility provide sufficient **qualified, trained, and competent** staff.	
Rule 16.03.15.203			
Comment from: DisAbility Rights Idaho			
V, W	There does not appear to be a requirement that any allegations of abuse, neglect, or mistreatment committed by an employee, as well as the results of any investigations into such allegations (i.e. substantiated or not substantiated) be kept in the personnel record along with any disciplinary actions taken against the employee and the reasons why such actions were taken.	DHW Response: Subsection (.12) added to incorporate this suggestion.	
Rule 16.03.15.204.02			
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council recommends specific language be added to the rules that address thorough and repeated training for all staff regarding the facility's definitions of abuse, neglect, and mistreatment paired with thorough and repeated training on the facility's policy regarding abuse, neglect, or mistreatment policy, including the requirement to report and how to do so. The Council is opposed to the use of restraint and seclusion as a programmatic tool. The Council advises the review of NADD's training and information materials on "Intellectual/Developmental Disabilities and Trauma" and	DHW Response: Section 204.02 have been revised to more clearly state the requirements. The requirements include ongoing training, education, and demonstrated knowledge. The Department acknowledges the Council's concerns. Section	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	"Safety without Seclusion and Restraint," located at: http://thenadd.org/resources/other-resources-of-interest/.	.511 was revised to clarify prohibitions on the use of physical restraints.	
Comment from: DisAbility Rights Idaho			
V, W	There does not appear to be any requirement that all staff be trained specifically as to the facility's abuse, neglect, or mistreatment policy and their reporting requirements under said policy.	DHW Response: Section 204.02 have been revised to more clearly state the requirements. The requirements include ongoing training, education, and demonstrated knowledge.	
Comment from: DisAbility Rights Idaho			
V, W	As to subsection (c.), (training for direct care staff), there does not appear to be any requirement that such staff complete their training prior to working directly with clients, which could lead to the potential misuse of restraints or other restrictive interventions as well as abuse, neglect, or mistreatment of clients.	DHW Response: Section .511c requires restraints only be used by trained staff.	
Comment from: DisAbility Rights Idaho			
V, W	Why are the training requirements in .204.02.c just limited to direct client care staff? DRI would require that all staff, including administrative staff, be trained on the elements listed in c.i – xii.	DHW Response: Training requirements in Section 204.02 revised to include the training is required for all staff.	
Comment from: DisAbility Rights Idaho			
V, W	DRI objects to the use of prone restraint.	DHW Response:	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
		Section .501 revised to add the prohibition of prone and supine restraints.	
Comment from: DisAbility Rights Idaho			
V, W	As to subsection (c., ix.), it appears as though the language of this subsection allows for the use of prone, supine, or other restraints. In reviewing the remainder of these rules, there does not appear to be any restrictions or limitations as to the use of prone, supine, or other restraints. Such restrains are inherently dangerous, inhuman, unnecessary, and should be banned from use in this facility.	DHW Response: Section .501 revised to add the prohibition of prone and supine restraints.	
Rule 16.03.15.300			
Comment from: DisAbility Rights Idaho			
V, W	Such protections need to be explained to a client and their guardian, if applicable.	DHW Response: Section 302 revised to incorporate this suggestion.	
Rule 16.03.15.301			
Comment from: DisAbility Rights Idaho			
V, W	There appears to be missing from this section the conditions for appointed advocates found in the IDAPAs for ICF/IDs, specifically 16.03.11.202 as well as the advocated rights found in 16.03.11.203. The decision making ability of the advocate (i.e. the ability for the advocate to provide consent) is also not clearly outlined in this section.	DHW Response: Section 301 revised to incorporate this suggestion.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.302.06			
Comment from: DisAbility Rights Idaho			
V, W	The term "promptly" is not defined and could be subject to broad interpretation. Additionally, allowing for a parent or guardian to be notified of any significant changes in a client's condition, including and especially death, in any timeframe less then immediately is inappropriate.	DHW Response: Subsection revised to require notification within 24 hours.	
Comment from: DisAbility Rights Idaho			
V, W	"Significant event" should include any injury the client experiences.	DHW Response: Section 302.04 revised to add injury to the situations considered a significant event.	
Rule 16.03.15.303.04(b)			
Comment from: DisAbility Rights Idaho			
V, W	If the "advocacy agency" referred to in this subsection is DisAbility Rights Idaho, then the term should be replaced with "the State protection and advocacy system" to be consistent with all other rules.	DHW Response: Subsection revised to incorporate suggestion.	
Rule 16.03.15.305(02)			
Comment from: Idaho State Independent Living Council			
V, W	This rule does not include the words neglect or mistreatment with the rule. We recommend that you include and apply these terms.	DHW Response: Neglect and mistreatment are both included in the Definitions section.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: DisAbility Rights Idaho			
V, W	It appears as though this section is missing language as the last sentence ends with, "The facility must." Additionally, the terms neglect or mistreatment are notably absent from the provisions of this rule.	DHW Response: Incomplete sentence corrected. Neglect and mistreatment are both included in the Definitions section.	
Rule 16.03.15.305(03)			
Comment from: DisAbility Rights Idaho			
V, W	This provision appears to conflict with a later provision of these rules, 16.03.15.520, which allows for chemical restraints.	DHW Response: The department sees no conflict. Section .520.02 clearly states the conditions under which medications can be used.	
Rule 16.03.15.305(04)			
Comment from: DisAbility Rights Idaho			
V, W	It is unclear how this provision aligns with the prohibition of isolation found in Idaho Code 66-412. Additional, why is isolation not prohibited in these rights?	DHW Response: Definitions revised to have "isolation" and "seclusion" used interchangeably. Seclusion added as a prohibited intervention listed in Section .501	
Rule 16.03.15.305(06)			
Comment from: ACLU of Idaho			
V, W	In considering required accommodations for protecting a patient's First Amendment right to practice their religion of choice, there is no specific mention that food	DHW Response: Section 305.06 states the right to practice religion includes	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	accommodations would be provided for those with dietary restrictions consistent with their religious beliefs. To ensure full protection of one's ability to practice their religious beliefs without restrictions, we recommend that these rules also include provisions to provide religiously necessary food accommodations consistent with constitutional protections of the First Amendment.	religiously necessary food accommodations.	
Rule 16.03.15.305(07)			
Comment from: Idaho State Independent Living Council			
V, W	This rule states that individuals "who do work for the facility must be compensated for their efforts at prevailing wages and commensurate with their abilities." The rule conflicts with the right of citizens to be paid prevailing wages for work done regardless of ability. If you are unable to provide appropriate work at prevailing wages that correlates with a person's ability, we suggest you seek out experts in the field of customized employment, such as the Idaho Division of Vocational Rehabilitation or the Idaho Council on Developmental Disabilities, Employment First initiative to determine appropriate work for the individual. This is an integral part of Person Centered planning when a person wants to gain employment and skills for employment.	DHW Response: The purpose and nature of this facility is such that a person's employment readiness and employment skill development will not be a primary focus.	
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council is opposed to the practice of paying individuals wages commensurate with their abilities. This is demeaning and is not best practice. Best practice would dictate that they earn the prevailing wage for someone doing the same work. The Council believes that the State of Idaho should model practice.	DHW Response: This section revised to state that persons who do work for the facility must be compensated at prevailing wages.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.310			
Comment from: Denise Myler			
W	I don't understand how restricting someone's access to their needed communication devices gives the staff or person any benefit. I see the denial of their communication device for the undefined time structure of temporarily restricted as punitive. The Department needs to also rethink mobility devices, canes, eyeglasses, and clothing and what benefit temporarily restricting these items will gain the person and staff.	DHW Response: Section .310.02 allows restriction of such devices ONLY if the restriction is necessary to assure the safety of the person, a staff member, or others.	
Rule 16.03.15.310(01)			
Comment from: ACLU of Idaho			
V, W	It is unclear for what reasons the facility may limit a client's right to communicate with individuals inside or outside the facility. The reasons for such restrictions should be clearly set out in these facility rules and communicated directly to patients and their guardian, if applicable. Also, the references made to "Subsections 306.05 and 306.06 of these rules" does not exist.	DHW Response: Section .310.02 allows restriction of such devices ONLY if the restriction is necessary to assure the safety of the person, a staff member, or others. Rule references in the entire chapter were reviewed and updated.	
Comment from: DisAbility Rights Idaho			
V, W	This rule references subsections "306.05 and 306.06 of these rules" which do not exist.	DHW Response: Rule references in the entire chapter were reviewed and updated.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.310(02)			
Comment from: Idaho State Independent Living Council			
V, W	It is unclear how "temporary" restrictions of supportive or adaptive equipment, such as communication devices or wheelchairs allow for a person to function as independently as possible as required in their ITP. Further, given that even clothing, eye glasses canes, and other needed items can be used as weapons, how long do you propose people go without. It is of particular concern that the restriction of ambulatory and communication devices will result in an individual being subjected to isolation and other inhumane circumstances. A person could potentially be without a means to communicate or move without help from staff. Additionally, the term "temporary" is random when left to broad interpretation.	DHW Response: Section .310.02 allows restriction of such devices ONLY if the restriction is necessary to assure the safety of the person, a staff member, or others.	
Comment from: ACLU of Idaho			
V, W	"Temporary restriction" is not defined and could be interpreted broadly, resulting in property being kept from a client for days or weeks on end without explanation.	DHW Response: Section .310.02 allows restriction of ONLY if the restriction is necessary to assure the safety of the person, a staff member, or others. Once the unsafe situation is resolved, the restriction will end.	
Comment from: DisAbility Rights Idaho			
V, W	It is not clear how temporary restrictions of supportive or adaptive equipment, communication devices, or basic clothing which may be used as weapons such as eyeglasses, canes, walkers, etc. aligns with the provision for an	DHW Response: Section .310.02 allows restriction of such devices ONLY if the restriction is necessary to assure	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	individual to function with as much independence as possible as required in their ITP.	the safety of the person, a staff member, or others.	
Comment from: DisAbility Rights Idaho			
V, W	It also is unclear how the restriction of such equipment or services would not result in an individual being subjected to isolation or in violation of any other rights found in Idaho Code §66-412 in that they could potentially be without a means to communicate or a means to ambulate without the assistance of staff.	DHW Response: Section .310.02 allows restriction of such devices ONLY if the restriction is necessary to assure the safety of the person, a staff member, or others.	
Comment from: DisAbility Rights Idaho			
V, W	The term "temporary" is not defined nor limited in its application and could be left for broad interpretation. Therefore, such items could be restricted for weeks, which again, does not appear to align with the protections found in Idaho Code §66-412.	DHW Response: Section .310.02 allows restriction of ONLY if the restriction is necessary to assure the safety of the person, a staff member, or others. Once the unsafe situation is resolved, the restriction will end.	
Comment from: DisAbility Rights Idaho			
V, W	Are "permanent restrictions" limited to just this facility or will these restrictions travel with the client to a lesser restrictive placement or community placement while under commitment? If that is the case, licensing will have exceeded its statutory authority to make rules for the secure facility.	DHW Response: The restrictions outlined in Section .310 apply only to the secure treatment facility.	
Comment from: DisAbility Rights Idaho			
V, W	.03 limits a client's ability to purchase a weapon. Every client eligible for this facility has either been civilly	DHW Response:	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	committed or is there under an 18-212 order, both of which trigger 18 U.S.C. 922 et seq. federal prohibition on the possession of firearms.	The limitation in Section 310.03 would then align with the conditions of a civil commitment.	
Rule 16.03.15.310(06)			
Comment from: DisAbility Rights Idaho			
V, W	Patient needs to be informed of refusal right regardless of guardian/advocate. Some type of hearing within facility with independent decision makers.	DHW Response: The rule in Section 310.06 reads, "The facility must inform each person, the person's legal guardian, AND the person's guardian of the right to refuse treatment or revoke consent for treatment without fear of reprisal."	
Rule 16.03.15.310.06(c)			
Comment from: Randy Harrold			
W	Clients being considered for admission to the secure facility should be required to go through a comprehensive behavior analysis by an independent qualified psychologist not affiliated with the facility. The client should have all medical needs identified by [sic] independent as appropriate behavior can be a direct result of physical pain. If the client is non-verbal or has a communication disorder, a communication assessment should be required from an independent qualified professional with qualifications that	DHW Response: The assessments required as part of the admissions process, outlined in Section 402 include a comprehensive behavior analysis, assessment of medical needs, and other needs and strengths. These assessments may be completed by qualified facility clinicians or outside qualified health care providers.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	best meet the needs of the individual client. Inappropriate behaviors can also be directly related to lack of communication.		
Rule 16.03.15.320.01			
Comment from: DisAbility Rights Idaho			
V, W	Again, restrictive treatment is not defined anywhere in these rules. Additionally, it is not clear from the provision who must provide the written consent.	DHW Response: Definition of "restrictive intervention" added to definitions. Section 320 clearly states the written consent must come from the person and the person's legal guardian.	
Rule 16.03.15.320(02)			
Comment from: Idaho State Independent Living Council			
V, W	We are strongly opposed to the use of any experimental research on residents held at this or any similar facility. There do not appear to be any restrictions in place as to such research, as are found in 45 C.F.R. §46, et seq. By definition of the individual's admission, residents are unable to provide informed consent. Further, guardians of people with developmental disabilities are statutorily prohibited from consenting to experimental treatment without having a separate court proceeding and the issuance of a court order authorizing such consent. See I.C. 66-405(10).	DHW Response: This section was removed from the rules.	
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council strongly opposes any experimental research on clients to be performed at this facility.	DHW Response: This section was removed from the rules.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Comment from: ACLU of Idaho			
V, W	We question the DHW's inclusion of potential experimental research for individuals within the secure treatment facility as it appears to be entirely outside the scope of the intent of this facility and the expected treatment patients charged under the Department's care expect to receive. The ACLU of Idaho is adamantly opposed to the inclusion of this kind of provision in the secure treatment facility rules.	DHW Response: This section was removed from the rules.	
Comment from: DisAbility Rights Idaho			
V, W	DRI is adamantly opposed to the use of any experimental research on clients being performed at this facility. It should also be noted that there does not appear to be any restriction in place as to such research as are found in 45 C.F.R. §46, et seq.	DHW Response: This section was removed from the rules.	
Rule 16.03.15.401			
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council recommends a detailed set of rules that addresses the education of the Human Rights Committee. Rules should address the facility's priority to provide continued education to members of the Human Rights Committee with the purpose of using best practice standards in their review of treatment plans for individuals. A set of rules should be included to emphasize the facility's priority to best practice and evidence based practice by hosting webinars, speakers, and attendance at NADD conferences provided to all staff, not limited to administrative staff.	DHW Response: Section .321 revised to include a requirement that the HRC members receive initial, ongoing, and refresher training.	
Comment from: DisAbility Rights Idaho			
V, W	It is not clear what "best practice" or "evidence based practice" means. It also is not clear from these provisions	DHW Response:	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	that trauma informed care principles will be incorporated in assessments for every client regardless if physical restraint and seclusion are to be used. See also our comments for 16.03.15.411.12.	Section 402.02 revised to incorporate this suggestion.	
Comment from: DisAbility Rights Idaho			
V, W	When compared to section .322.01, criteria the human rights committee must review to approve restrictive practices, it appears that "best practice" and "evidence based practice" is only required for treatment but not for restrictive practices. For example, the secure facility may use a non-best practice or a non-evidence based restrictive treatment on a client.	DHW Response: Documentation of HRC monitoring found in Section .322.01 includes monitoring of treatment as well as restrictive practices.	
Comment from: DisAbility Rights Idaho			
V, W	Moreover, the human rights committee is to ensure that the client, legal guardian, or client advocate has provided written informed consent to use a restrictive treatment (.322.01.g). However, for all clients in this facility, the ONLY person who could provide such consent would be a court-appointed guardian who has been granted the power to consent to treatment.	DHW Response: Section 322.01(g) does require that only the person's legal guardian can provide written informed consent.	
Rule 16.03.15.402			
Comment from: ACLU of Idaho			
V, W	We once again recommend that all the statutory admission criteria under Idaho Cod 66-1404 for admission into the secure treatment facility be explicitly referenced in this provision.	DHW Response: Since statute overrides rules, it is generally not advised to restate statute in administrative rules. This rule chapter aligns with Chapter 14, Title 66, Idaho Code.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.402(2)			
Comment from: DisAbility Rights Idaho			
V, W	It needs to be made explicitly clear in these rules that a person can only be admitted to this facility if all of the admission criteria found within Idaho Code §66-1404 are met.	DHW Response: The definition of "person" was added to the Definitions section and references the criteria in Section 66-1404, Idaho Code.	
Rule 16.03.15.411(2)			
Comment from: Denise Myler			
W	What will be the standards of independent living skills to be taught? I would suggest the besides teaching skills at the facility, a person will be able to exercise their training in the community, i.e. Wal-Mart or Burger King. Also, I would suggest the person live 3-4 months in the community, say at a group home, to see how their skills are and if additional independent living skills training is needed so the person can be successful living back in the community.	DHW Response: The purpose and nature of this facility is such that a person's employment readiness and employment skill development will not be a primary focus.	
Rule 16.03.15.411(12)			
Comment from: DisAbility Rights Idaho			
V, W	It is not clear from this rule that trauma informed care principles will be incorporated into every assessment for every client regardless of whether restraints are to be used. As all clients in this facility are subject to emergency use of such restraints, all clients should be assessed using trauma informed care principles and risk factors for restraint. Trauma informed care should not be restricted to restraint. A thorough knowledge of the client's trauma history is essential to avoiding trigger events that interfere with	DHW Response: Definition of trauma-informed care added to definitions. Training requirements in section 204.02 revised to add requirement that professional program staff receive training in trauma-informed care and in person-centered planning.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	treatment or may precipitate situations which require restraints.	Subsection added to Section 402 to include requirements for comprehensive trauma history and de-escalation strategy information, and an assessment of individual needs and strengths. Added language to section 502 to require policies and procedures align with trauma-informed care and person-centered planning principles.	
Rule 16.03.15.441			
Comment from: ACLU of Idaho			
V, W	This provision fails to conform to the statutory discharge requirements under Idaho Code §66-1405(4), which requires that "the director or the director's designee shall review the patient's progress every ninety (90) days to determine whether the patient continues to meet the program criteria." Without any inclusion of a review policy, there is no assurance that a person admitted to such a facility will not be allowed to languish there for years without appropriate oversight.	DHW Response: Section .441 revised to incorporate these suggestions.	
Rule 16.03.15.441(02)			
Comment from: DisAbility Rights Idaho			
V, W	The term "reasonable time" is not defined and is open to interpretation as to what "reasonable time" to prepare for a transfer or discharge may be. Additionally, it is not clear	DHW Response: Section .441 revised to incorporate these suggestions.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	how this provision complies with the requirements of Idaho Code §66-1405.		
Rule 16.03.15.501			
Comment from: DisAbility Rights Idaho			
V, W	It appears as though the language of this subsection allows for the use of prone, supine, or other restraints. In reviewing the remainder of these rules, there does not appear to be any restrictions or limitations as to the use of prone, supine, or other restraints. Such restraints are inherently dangerous, inhuman, unnecessary, and should be banned from use in this facility.	DHW Response: Section .501.05 added to prohibit prone and supine restraints.	
Rule 16.03.15.502(01)			
Comment from: DisAbility Rights Idaho			
V, W	Considering the recent, well-publicized issues at the State-run ICF/ID, there should be the addition of policies and procedures that must identify what constitutes abuse, neglect, and mistreatment of a client as well as the reporting requirements that staff must follow if abuse, neglect, or mistreatment is suspected. There should also be some quality assurance policies, practices, and procedures incorporate into these rules as well.	DHW Response: The definition of "abuse" has been revised to clarify what constitutes abuse. This rule chapter outlines the licensing requirements for the facility. Further details about quality assurance policies and practices will be included in the facility's policies and procedures.	
Rule 16.03.15.511			
Comment from: Idaho Council on Developmental Disabilities			
V, W	The Council is opposed to the use of restraint and seclusion as a programmatic tool. The Council advises the review of NADD's training and information materials on	DHW Response: Section .511 states that physical restraint can only be used for the	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
	"Intellectual/Developmental Disabilities and Trauma" and "Safety without Seclusion and Restraint," located at: http://thenadd.org/resources/other-resources-of-interest.	management of violent or self-destructive behavior after less restrictive interventions have failed. Language added to this section that alternative measures must be used if the physician or clinical case manager identifies any risk associated with use of the physical restraint.	
Rule 16.03.15.511.02(f)			
Comment from: DisAbility Rights Idaho			
V, W	Given the discussion above, an evidence based, recovery oriented, trauma informed program would not allow the use of restraint or seclusion as a "therapeutic" part of a treatment plan. Individual Treatment Plans should contain information on medical issues, trauma history, and alternative strategies which would limit the use of restraints or seclusion and would dictate specific techniques or risks to be avoided. Subsection (f) should be rewritten to clarify that it is not intended to create an exception to the general language of subsection 511.02, but to specify that conditions surrounding use of restraints and seclusion as allowed in subsection 511.02 must be addressed in the treatment plan. This section should also specific time tables for physician reviews, debriefings, and data collection in line with SAMHSA's recommendations for reducing restraint and seclusion and implementing trauma informed care principles.	DHW Response: Section .511 states that physical restraint can only be used for the management of violent or self-destructive behavior after less restrictive interventions have failed. Language added to this section that alternative measures must be used if the physician or clinical case manager identifies any risk associated with use of the physical restraint.	

W-Written V-Verbal	Comments	Responses	Justification for Not Incorporating the Change
Rule 16.03.15.520			
Comment from: DisAbility Rights Idaho			
V, W	Use of prescription drugs to treat anxiety, panic attacks, or extreme agitation, when administered in appropriate doses, are not chemical restraint. However, drugs administered for the purpose of sedating or restricting the movement of patients or at dosages which exceed those appropriate for treatment of symptoms should be prohibited.	DHW Response: "Punishment" has need added to the definition of abuse in the Definitions section. Punishment includes the use of drugs used as chemical restraint and is prohibited. A definition of "chemical restraint" has also been added.	

ATTACHMENT 8

IDAHO DEPARTMENT OF HEALTH & WELFARE

Testimony Related to the Secure Treatment Facility

The following is a transcript from the testimony given by the Canyon County Sheriff's Office during the Negotiated Rulemaking Session held on January 24, 2018 related to the Secure Treatment Facility. The testimony does not comment on any specific sections of the proposed licensing rules found in Docket 16-0315-1801, but it is testimony related to the establishment of a secure facility.

Transcript of Testimony:

Sherriff Donahue, Canyon County Sheriff: I represent Canyon County Sherriff's office and I'm the president of the Idaho Sherriff's Association, and I will be representing them today as well. First and foremost, I just want to thank you for the opportunity, I know that this has been a long, drawn-out process...and also thank the deputy director for the collaboration that we've shared for these long many months. A lot of meetings and quite frankly from our prospective, those of your who have walked into a jail...hopefully you've never been to a jail for the wrong reasons, but jails are not fun places. They're not fun for the people who work there, and they're certainly not fun for the people who have to live there. They're a lot less nice and polite for those with disabilities or issues as individuals in the mental health field. And so, I think that what the director has talked about for you as well and Cameron, is the safety of these individuals. That is paramount in our eyes as sheriff's. The Sherriff of every county is mandated to operate a jail. We are mandated by law – we don't have a choice, we have to operate that jail. There are numerous that can go on in a jail at any given day, at any given moment. And so, the safety of these individuals becomes paramount because we have very limited places to house them as you can imagine. We do not and will not house them in general populations based on the conditions that they're there with their own disabilities or concerns for them. So that means like in our particular jail, they live in places called special management units. They may or may not be able to live in those management units by themselves just because on the sheer numbers of induvial at the jail on any given day. Safety of them as individuals is to us is paramount and I think that's why this legislature we testified numerous times last year in both the house and the senate and really are interested are interested to make sure that they are taken care of. Jail is not the place for them. How do they get to jail? Well, they commit crimes. Currently they are allowed by proxy to leave the facility with their living, their housing units because we haven't had a facility to house them in. It's not the staff of H&W's fault, it's not the community's fault, but the fact is that these people go out and commit crimes. And they commit victimization of innocent people, property owners, etc. Once they're taken charge, and taken to jail like ours or any other jail in the state,

they're housed. Not only are perhaps a danger to themselves and others, they do become a danger to our staff just like they are a danger to the staff at SWITC. And, I can tell you that just in our jail that one individual that kind of what got this movement forward in legislation. That individual injured 9 of our staff over a year and a half. Three of those seriously to where they were out on FLMA, and one particular individual still has the possibility of losing her arm because the injury sustained and subsequent surgeries and medical care...just one incident with that one individual. That's sad all the way around. That's terrible. It's terrible for the person we had to house there, and it's terrible for the staff member. There's no win-win situation. That's just one example, we have other examples.... Again, I don't think we're testifying to the fact that we're going to have this secured facility that we passed in legislation. There really is some underlying needs. We have another individual who has disabilities from a medical standpoint. He's in jail. Jail inmates have all the time in the world to come up with really crazy terrible ideas. This individual have encouraged him to do damage to himself, because they have all day, and some of these people are not very nice. They just are not very nice people...but having his conditions, they've encouraged him to do damage to himself. How can we justify that? Other individuals we've housed from SWITC who have committed crimes, landed in the judicial system and who are seriously a danger to themselves and others. They're developmentally disabled.... some have been found incompetent to stand trial. And when they're found incompetent to stand trial, that's part of our history with H&W over the past few years. Where do we put these folks where there's not a secure place to hold them as they go through this process. And we've even gone to extraordinary lengths of housing them in the prison at the opting of the Idaho Department of corrections director because we had no place to house them. Just think if that were your family, your sibling, your daughter, your son.... You're now getting in to constitutional law for housing someone who has not been convicted of a crime. So that constitutional rights come into play as well. So this is a pretty complex issue in the way we look at it. Then it all comes back to the safety of the individual, the safety of H&W staff who has to manage these individuals...and of course the safety of community if they're out of the facility. And of course, the safety of the staff in our county jails or the prison as it were. So, I think that's a big share of what we wanted to pass on. I really appreciate (Cameron) your extensive explanation of a number of the people in our state who have issues...individuals that are really only a very small percent ever come through the doors of SWITC. I think that's really something that can't be lost on any of us. We're talking about a very small population. And yet they're a population that we're having to spend a lot more time. It's incumbent on us as society, it certainly is as law enforcement, that these are our community members and they are one of us and we need to take care of them in the best way we possibly can. We have that duty as individual and as citizens, obviously we take an oath as law enforcement...overall these are our people. Regardless of what has happened to them in their life and unfortunate things they're going through. So, that can't really be underscored enough in our opinion. So, we're thankful that you're going through the process. The rules and policy...that's lengthy, we've read it. That's a lot of stuff. So, I don't envy your jobs. I don't envy my staff either for having to really read more thoroughly than I had do. Today, I have my health science administrator and

well as one of my lieutenants from the jail. Long time experience, both of them. We've listed them to speak...but we're going to go ahead and step aside and let others speak to make sure you get everything through. I think that if there's some questions that we can answer for folks, we'd be glad to do so. Or if we have a chance to, if it's appropriate after other people have spoke, we'll do so. Thank you.

Josie Murray (Canyon County Sheriff's Office): We have pretty much agreed with just about everybody. Everyone brought up really good points. I don't think we disagreed with anything everyone said. There was one other thing, where I just had a small question. In the definition of punishment where it talks about modifying a client's diet, or withholding food or hydration... Obviously, I do agree with the use of restrictive intervention such as physical and chemical restraints just as long as it's emergency...things like that. But modifying a client's diet, withholding food or hydration, maybe I'm just misunderstand that...or maybe that was copy and pasted from an older module or something.... I don't know what exactly that means.

I just wanted to make sure that that's what we were saying because I know that we are using restraints later, but then I wanted to make sure that we were not going to withhold any food or hydration or anything like that. Also, just to touch on it really quick.... We are all on the same page and we do agree with Jim and the ACLU. Our whole goal.... we are on the same page. Even with miss So and So and her son. The people that we're looking to put in this facility are ones that we want to keep out of the jail and it's not the people who just have a behavioral issue. It's the people who are very dangerous...that are bashing the nurse's heads off the floor, they're grabbing them by the hair, they're curb stomping them.... they're doing things that are very dangerous. NO just behavior issues. I know that we have students in here and I don't want them walking away thinking that it's just somebody with a behavioral issue, they have to have a dual diagnosis. They're very dangerous. I know we're talking about laws and regulations and things...just so we walk away with a full idea here. These people that we're talking about don't' understand that full consequences of their behaviors. That's why we need this facility and we need to get all these regulations laid out and we need to be on the same page. I mean, when they do go and break the windows and their allowed to walk away...I want her to feel safe with her son if he does happen to end up in a facility like this...it's only if he gets to that point where it is a very dangerous situation. If he does walk out of the current facility where they don't have these rules in place and he goes and breaks a window and picks up that glass and he walks up to somebody with it... he might not understand that he might hurt somebody in the community if I walk up and put that glass up to their neck. I could actually kill someone and that's why they end up in jail because they don't understand those full consequences. And we want to prevent that.... it's about prevention. Not about punishing someone and just throw them away in some locked facility. We need to establish these rules to keep them all safe to prevent them from having to come to jail. Jail, obviously yes, we have medical staff...but it's not a place for people like this. Anyway, that's all we had.

ATTACHMENT 9

The current nursing home building is 80 years old. The current Nursing Home building was built in 1938 and later retro fitted to become a nursing home. The original use of the building was a medical clinic and surgical hospital setting. This building has never been an ideal building for nursing home residents.

Profile of Residents of SHS Nursing Home

- **Residents are involuntarily committed by the court or under a court ordered guardianship**
- **Suicidal** actions or a demonstrated desire to hurt themselves
- **Voiced Desire to Harm** others or have taken the action to harm others
- **Lacking Life Safety Skills** demonstrating the inability to care for basic life functions such as eating, dressing, medical care and protecting themselves from environmental harm
- **Diagnosed** with a Behaviroal, Cognitive and/or Mental Health Disorder
- **Placement Failures** including eviction from several community nursing homes impacting them to the point of needing State care to avoid becoming homeless
- **Close Oversight** of Psychiatric, Medical, Nursing and pharmaceutical care is required due to managing aging (65+ years) with multiple physical and cognitive complications

Resident needs that cannot be addressed in the current building

- **Space needed to use adaptive equipment** Many rooms do not have the space needed to use adaptive equipment for residents whose weight makes them immobile. Special equipment is needed to assist with bathing, moving these residents from a bed to a wheelchair and other activities of daily living
- **Current building has 4 floors** This building is multi floored which creates huge safety risks for resident evacuation in emergency situations
- **Current building lacks food services** All food must be prepared in a separate building and wheeled across the campus 3 times a day, the distance is longer than 2 football fields between the buildings. This has created a large challenge for many years. The food must remain at a constant temperature and you can imagine how the weather (rain, snow and wind) impact the ability to bring warm food to the residents for each meal
- **Safe oxygen supply needed** There is no capacity to supply oxygen from a central location into each patient bedroom. Using large oxygen tanks in the resident's bedrooms is a safety risk but is currently the only option in the building
- **Lack of full physical therapy program in the building** The Nursing Home is required to have a physical therapy program for the residents. The nursing home currently must transport the elderly patients to another building or use limited equipment to address the residents needs
- **Limited number of licensed Nursing Home beds** Because of the limited number of nursing home beds at SHS, committed residents are placed in the hospital awaiting an opening for a nursing home bed. This places very vulnerable 65-year-old and older patients in a high-risk setting creating a safety concern

Risks and existing challenges we face with our current building

- **Staff injuries** There is increased exposure to workman's compensation claims due the limited ability to use adaptive equipment for the residents
- **Emergency backup power** There is insufficient access to emergency backup power. Standards require a 24-hour generator back-up for all the medical equipment, electronic medical record and medication administration in the building, which it currently cannot provide
- **Wi-Fi access** The building needs to have uninterrupted access to Wi-Fi, currently this is not available in the building. This is vital to access the electronic medical record and safety/duress system
- **Plumbing** The plumbing in the current building is inaccessible for maintenance and repair. The main pipes run down concrete encased pillars. Many pipes in the current building have not been replaced in 80 years which most likely compromises the water quality

- **Elevators** The current building has elevators that often break down and create a safety risk to both staff and residents
- **Resident safety in confined spaces** Residents who are in wheelchairs have a challenge because there are not wide-open spaces where they can pass one another freely. With the emotional and behavioral challenges that the residents face, moving or bumping into someone can often cause great agitation and emotional outbursts

Justification for the space being requested:

- **Building for projected expansion capability** The current building is limited to 29 licensed nursing home beds. The proposed building footprint will have the capacity to serve 59 residents. When the building is opened it will likely expand to 36 licensed beds. As the population of elders continues to grow in Idaho, it will have the ability to expand bed space to a total of 59 residents without requesting any additional changes to the building
- **Adding a dedicated commercial kitchen** into the new building will require additional space and cost. The kitchen is required to meet industrial standards. This impacts the budget because of the additional space needed and the cost of dishwashers, refrigeration, ovens and other necessary equipment needed to meet those standards
- **Bedroom and bathroom space for adaptive equipment** Each room has a regulatory mandated square footage for the number of residents using each space
- **A medical exam room** in the building is needed. Residents must meet medical necessity to be in a nursing home and suffer from behavioral health issues or cognitive impairment. Many residents are resistive to leave the building to seek medical care
- **Family style dining and visiting areas** Regulations require an environment as "home like as possible". There must be a family style dining area and visiting area where family members can come
- **Information & Technology room, Sprinkler riser room** The current building does not have space for IT. The sprinkler system was a retro fit in this building and the new building will need to have additional space to adequately address fire safety
- **More open and wider spaces** in hallways and dining areas are needed for safety. This requires additional space to the building footprint.
- **Recreational Therapy Room along with the Multi-Purpose Therapy Room** is anticipated to be used not only by the residents of the Nursing Home but by the other patients on the SHS campus. Along with its anticipated use for large group activities it will also be used weekly for chapel services. This space will add to the footprint of the building but helps us address a future need when the last of the old buildings (built in 1942) currently in use on the SHS campus is demolished.

MOTIONS
By
BOARD OF HEALTH AND WELFARE

MEETING DATE: **February 22, 2018**

Licensing and Certification: Secure Treatment Facility for People with Intellectual Disabilities
Docket No. 16-0315-1801

I, _____, move that the Idaho Board of Health and Welfare adopt the "Temporary" rules for "Secure Treatment Facility for People with Intellectual Disabilities", presented under Docket No. 16-0315-1801, effective February 22, 2018.

MOTION BY: _____

SECONDED BY: _____

VOTE: Voice Vote: ____ Roll Call: ____

	Aye	*Nay*	*Absent*	*Abstain*
Mr. Kerby				
Mr. Giuffre				
Ms. Hatzenbuehler				
Dr. Roberge				
Mr. Stroschein				
Ms. Jaquet				

CONVENE AT: _____ ____ ADJOURN AT: _____ ____ ____

Time Sensitive Emergencies (TSE)

Background

Numerous studies throughout the U.S. have demonstrated that organized systems of care improve patient outcomes, thus reducing the frequency of preventable death, and improving the functional status of the patient. Organizing systems of care around specific time sensitive emergencies such as trauma, stroke and a particular type of heart attack called a ST-segment elevation myocardial infarction (STEMI), can have significant impacts.

In 2013, the Idaho Legislature passed HCR10 forming a workgroup that would define the elements of a TSE Program, including funding mechanisms and an implementation plan; and drafting legislation for consideration by the 2014 Legislature. The 45-member workgroup, comprised of a variety of stakeholders, including emergency medical service providers, hospitals, healthcare providers, public health, health insurers, rehabilitation providers, legislators and community members presented legislation that was signed into law on March 19, 2014.

TSE is governed by a governor-appointed Council that makes the designation determinations. The TSE Program located in the Division of Public Health Bureau of Emergency Medical Services and Preparedness, reviews applications by health care systems, conducts onsite assessments, and runs the day to day operations of the program. Regional TSE Committees are established consisting of representatives from local emergency medical services, hospitals, public health, and others. The regional committees are the venue in which a wide variety of work is conducted such as education, technical assistance, coordination, and quality improvement.

The TSE Program is funded by the collection of fees from healthcare facilities voluntarily seeking TSE designation as a trauma, stroke or STEMI hospital and at varying levels. Each level of designation has different criteria and a different designation fee. See the table below.

Fees

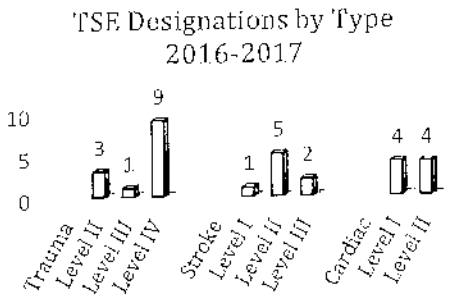
The designation fees are for a three (3) year designation and are payable on an annual basis.

Trauma Designations		**Stroke Designations**	
Level I	$45,000 ($15,000/yr.)	Level I	$21,000 ($7,000/yr.)
Level II	$36,000 ($12,000/yr.)	Level II	$12,000 ($4,000/yr.)
Level III	$24,000 ($8,000/yr.)	Level III	$1,500 ($500/yr.)
Level IV	$12,000 ($4,000/yr.)	**STEMI Designations**	
Level V	$3,000 ($1,000/yr.)	Level I	$21,000 ($7,000/yr.)
Pediatric Level I and Level II	$36,000 ($12,000/yr.)	Level II	$1,500 ($500/yr.)

Total Designations

The TSE Council made 14 designations in 2016, and 15 more in 2017, for a total of 29 TSE designations over the past 2 years.

Table 1: Total TSE Designations by Type



Facilities Designated as of February 1, 2018

Name of Facility	Trauma	Stroke	STEMI
Saint Alphonsus Regional Medical Center	Level II	Level I, Level II	Level I
Eastern Idaho Regional Medical Center	Level II	Level II	Level I
St. Luke's Boise		Level II	Level I
St. Luke's Meridian		Level II	Level I
Lost Rivers Medical Center	Level IV		
Clearwater Valley Hospital	Level IV		
Teton Valley Hospital	Level IV	Level III	Level II
Kootenai Health	Level II		
St. Luke's Magic Valley		Level II	Level I
Boundary Community Hospital	Level IV		
Bonner General Health	Level IV	Level III	Level II
St. Luke's Nampa			Level II
St. Luke's Fruitland			Level II
St. Joseph Regional Medical Center	Level III		
Steele Memorial Medical Center	Level IV		
Nell J. Redfield Memorial Hospital	Level IV		
Madison Memorial Hospital	Level IV	Level III	Level II
Syringa Hospital	Level IV		
St. Mary's Hospital	Level IV		
West Valley Medical Center			Level II
Caribou Memorial Hospital	Level IV		
Bear Lake Memorial Hospital	Level IV		

*Pending Application/Designation

SFY19 Budget Request

DU 12.26 - The TSE Program has only recently begun designating facilities and subsequently collecting fees as receipts. These receipts are deposited into the TSE Dedicated Fund 0192. The current spending authority for this dedicated fund is $127,000 in operating. It is anticipated that program receipts will exceed the current spending authority in SFY 2019. The Division of Public Health is therefore requesting an $200,000 increase in spending authority for the TSE Dedicated Fund 0192 in operating. The intent of this program is to become self-funded and utilize fees and potentially future federal grants for the designation process and community support.

ATTACHMENT 11

Advanced Care Planning Registry and Prevalence Program
Health Quality Planning Commission (HQPC) White Paper

Problem Statement

Seventy-five percent of people in life-threatening situations or nearing end of life cannot make or communicate decisions about the medical care they want.[1] Family members and health care providers face daunting decisions when a person's preferences are unknown. The default is to treat, leaving families and providers guessing if treatment is what that person wants. Ninety percent of Idaho adults say that talking about these future decisions (advanced care planning conversations) with family and health care providers is important, but less than one-third have done so[2] and only a small fraction of Idaho's adult population has submitted an advanced directive document to the Idaho Healthcare Directive Registry.[3]

Proposed Solution

Addressing these profound disconnects requires:
(a) increasing the prevalence of advanced care planning conversations that include *discussions of goals and preferences for medical care in the event a person is unable to make his/her own health care decisions.*
(b) documenting individual's informed preferences through advanced directives and Physician Orders for Scope of Treatment documents.
(c) improving outdated, poorly utilized document registry technology.
(d) communicating individual's preferences across settings of care.

State-wide, systematic, standardized advance care planning and registry improvements will result in continuity of care, respect for individual's freely-made informed decisions, matching of medical care to individual's informed preferences, and preventing harm and suffering by providing only medical care individuals say they want.

Factors Critical for Success

Alignment with the Charge of Health Quality Planning Commission. The problem and solution outlined above align with the charge outlined in Idaho Statute 56-1054 that created the Health Quality Planning Commission (HQPC). Specifically, the statute directs the (HQPC) to improve health outcomes through investment in health information technology and networked electronic health information that allows quick, reliable and secure access to promote patient safety and best practices. Furthermore, the HQPC is to make recommendations to the legislature and the Department of Health and Welfare on opportunities to improve the capabilities of health information in the state. This white paper is crafted to help address this directive while addressing the requirements outlined in the problem statement.

Recommendation

Public Private Partnership. The HQPC recommends that the generation of an effective advanced care planning system for all Idahoans (improved document registry technology, statewide training/engagement focused on prevalence and quality in planning, and broad utilization of the technology) be accomplished through meaningful partnerships between the Idaho Department of Health and Welfare, other state agencies, and private stakeholders such as payers, providers, businesses, nonprofits and others. The partnerships will focus on the development, funding, scaling, accountability, and sustainability of two objectives:

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[1] Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Institute of Medicine of the National Academies, 2014
[2] Idaho End-of-Life Survey, Boise State University, 2006
[3] Personal communication with Idaho Secretary of State's Office.

Objective (1): Establish the infrastructure and technology to support a web based document registry.
Achievement of this objective will establish a secure, accessible, sustainable mechanism to ensure documented advance care plans (advanced directives and Physician Orders for Scope of Treatment) are available wherever and whenever individuals and health care providers need them. The registry must be appropriately accessible to consumers, Idaho health care providers across settings of care, and Idaho emergency responders. The Department of Health and Welfare in partnership with the HQPC has detailed the specific characteristics, capabilities, and staffing needs for the electronic system and has assessed a vendor capable of supplying the technology solution. Financial projections for the initial 3-year period are included in Appendix A and totals $942,452.

Objective (2): Integrate evidence-based advanced care planning practices statewide.
Achievement of this objective will embed standardized, evidence-based advanced care planning practices within health care and community organizations statewide, enabling these organizations to (a) increase the prevalence of high quality advance care planning conversations between individuals, family members, and health care providers; (b) promote completion of appropriate documents; and (c) increase utilization of the web-based document registry by consumers and providers. The HQPC recommends scaling the Honoring Choices® Idaho (HCI) initiative to accomplish this objective given the progress and investment of $1 million by Saint Alphonsus and St. Luke's Health Systems toward this effort. HCI, an established advanced care planning collaborative convened by Jannus, Inc., has detailed a plan to integrate advance care planning skills and practices within 200 health care and community organizations and conduct statewide consumer outreach, creating a consistent model of advanced care planning that provides routine opportunities for Idahoans' and their families to participate in planning conversations. Financial projections for a 3-year period are included in Appendix A and totals $2,336,848.

Next Steps
(1) Engage stakeholders statewide. Priority is to leverage existing networks/collaboratives, coordinated care models, and membership organizations.
Include leaders from: regional health systems; private and public insurers; hospitals (Idaho Hospital Association); primary care and patient centered medical homes; post-acute care networks (Idaho Healthcare Association, Idaho Medicaid Healthy Connections Value Care Program, State Healthcare Innovation Program Regional Collaboratives); community health centers (Idaho Primary Care Association); Idaho Medical Association; Idaho Commission on Aging/Idaho Association of Area Agencies on Aging; Secretary of State's Office; and Employers Health Coalition of Idaho (employee wellness programs). Additional stakeholders to consider: Idaho Bar Association; Public Employee Retirement System of Idaho (PERSI); Chambers of Commerce; palliative care/hospice; and others.
(2) Engage facilitator.
Develop a scope of work and timeframe. Determine funding mechanism to support facilitator and partnership meetings.
(3) Convene stakeholders and establish planning group(s).
Facilitated, focused meetings will determine priority deliverables and mechanisms, success measures, risk mitigation, funding requirements, and develop a sustainable financing model. The HQPC expects recommendations from the planning groups by June 2018.
(4) HQPC reviews recommendations for public-private partnership.
Based on its review and consensus around planning group recommendations, the HQPC will make its recommendations to the Idaho Legislature to address the objectives of this white paper.

Financial Projections

The projections shown in Appendix A reflect the 3-year estimated costs for Objective #1 (web-based document registry technology and the staffing to support a system) ($942,452)[4], and for Objective #2 (statewide training, capacity building, and outreach) ($2,336,848). Again, these two features of an advance care planning system need to be orchestrated in order to maximize the success of each.

Projections for the 9-month costs for facilitation and planning meetings total $12,000.

Summary

A public and private partnership-driven approach to know and honor Idahoan's wishes for medical care will improve the quality of the health care experience for individuals and their families in profound ways. Driving improvements in web-based document registry technology and scaling a systematic approach to advanced care planning will improve the prevalence and outcomes of planning and achieve the ultimate of person-centered care—Idahoan's getting to communicate decisions about the care they want.

[4] Additional costs to individual health systems may occur for EMR integration.

APPENDIX A

Idaho Advanced Care Planning Registry and Prevalence Program

		Year 1 (SFY 20)	Year 2 (SFY 21)	Year 3 (SFY 23)	Justification
Objective #1: Establish the infrastructure and technology to support a web based document registry.	(See note below)				
Technology		$ 179,000	$ 22,500	$ 22,500	Y1: Cost includes annual license, conversion of existing registry documents records to new system, one-time perpetual license. Y2: Cost includes annual license. Note: there is an option for a 'subscription fee' for hospitals/health systems to integrate product to EHR based on annual Medicare discharges (only impacts larger health systems). Subscription not necessary as hospitals can use web-based product.
Personnel		$ 241,235	$ 235,082	$ 242,135	This includes three staff to support the registry contracts, use, hospital coordination, etc. Costs include salary and benefits for 3 FTP. It also includes $3,000 in capitol outlay for office furniture for staff (one time SFY 20), and $10,000 ongoing for operating expenses and technology training. Salaries calculated at 3% increase each year.
Health Program Manager (M)	*$ 81,593*				
Interoperability / Data Quality Coordinator (M)	*$ 74,281*				
Program Specialist	*$ 72,361*				
Subtotal:		$ 420,235	$ 257,582	$ 264,635	$ 942,45
Note: This cost is based on a bid of $1 per record transferred from existing registry to new one. This cost could be higher. Personnel costs are based on costs of managing similar data systems but may be less depending on the requirements of the vendor.					
Objective (2): Integrate evidence-based advanced care planning practices statewide.					
Honoring Choices Idaho program to integrate advance care planning skills and practices within 200 health care and community organizations		$ 554,587	$ 584,587	$ 597,674	HCI is currently funded by SAHS and SLHS and conducts training and mentoring of health and community organizations in the Treasure Valley and health systems' catchment areas. A statewide, detailed dissemination budget has been provided for this three-year scaling effort. Subsequent years will focus on sustainability.
Statewide outreach/marketing		$ 200,000	$ 200,000	$ 200,000	Theses costs are for a marketing campaign focused on diverse audiences (providers and consumers) to participate in advance care planning conversations and complete ACP documents. The campaign will also direct providers and consumers to use the registry, ensuring the investment in the technology results in high utilization.
Subtotal		$ 754,587	$ 784,587	$ 797,674	$ 2,336,848
Yearly Total		**$ 1,174,822**	**$ 1,042,169**	**$ 1,062,309**	**Grand total for 3 years:** **$3,279,300**

DHW Remote Login Instructions – Headline News

DHW Board members can now access the department's **Headline News** articles located within the internal SharePoint page, commonly called the **Infonet**.

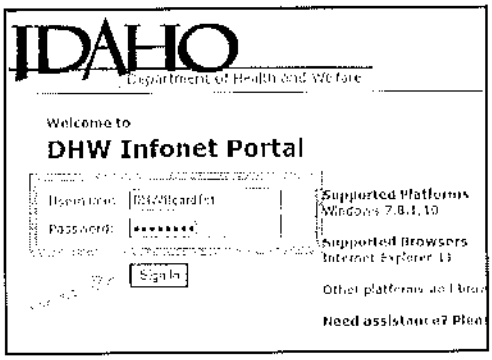
To Access the DHW Infonet for Headline News:

1. Open your computer web browser, such as Internet Explorer.
   - Type in the following address: https://rap.dhw.idaho.gov/infonet

2. Click on Proceed on the 'Pre Sign-In Notification' message.

3. Each Board Member will receive a username.
   - Enter **Username** and **Password**
     The password will initially be:
     - ***First 4 letters of last name (first letter capitalized)*** *and* ***last 4 numbers of primary phone***
   - Click **Sign In**

   Note: *The DHW IT Service Desk phone number is listed on this Sign In page, if help is needed.*

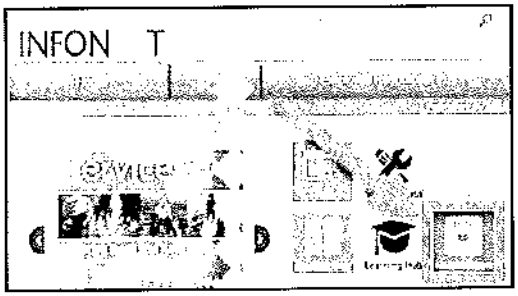


4. The first time you sign in, you will be prompted to **set a new password**. Enter the password you initially used to sign in, then choose a new password.
   - **Password rules**
     - Passwords must be a minimum of 8 characters
     - Must contain **at least 3 of the 4 following elements**:
       - upper case letters (A-Z)
       - lower case letters (a-z)
       - numbers 0-9
       - special characters (!@#$%^&*())

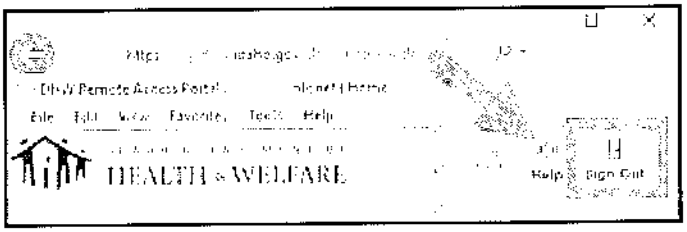
   Note: Passwords expire every 60 days and you may not use any of your previous 24 passwords.

5. A new login page appears. **Log in** using your username and the **new password**.

6. At the DHW Remote Access Portal page:
   - Click on **Infonet** to be directed to the Infonet homepage
   - Headline News is the blue box icon located on the right.



7. When finished, go back to the DHW Remote Access Portal browser tab
   - Click **Sign Out**



Additional Info: Passwords need to be changed every 60 days. You will be prompted to change your password at log on, if your password has expired. Also, your account will be deleted if you do not login every 90 days. This is due to a security policy within DHW.

For assistance, call the IT Service Desk at (208) 334-5673 – select option 1, then 2

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0104-1701 Board (companion to 0204-1701)	Emergency Medical Services (EMS) – Account III Grants	John Cramer 208-334-4000	**Pending 16-0104-1701 Pgs. 21-29**	Approved 1-11-18	**Pending 16-0104-1701 Pgs. 21-29**	Approved 1-16-18
0202-1701 EMS Physician Commission	Rules of the EMS Physician Commission Procedures and Testing to be Performed on Newborn Infants	Dr. Curtis Sandy, Chair 208-705-7752 Wayne Denny 208-334-4000	**Pending 16-0202-1701 Pgs. 30-32**	Approved 2-08-18	**Pending 16-0202-1701 Pgs. 30-32**	Approved 2-07-18
0204-1701 Board (companion to 0104-1701)	Rules Governing Emergency Medical Services Account III Grants	John Cramer 208-334-4000	**Pending 16-0204-1701 Pgs. 33-35**	Approved 1-11-18	**Pending 16-0204-1701 Pgs. 33-35**	Approved 1-16-18
0210-1701 Joint	Idaho Reportable Diseases	Leslie Tengelsen, PhD, DVM 208-334-5941	**Pending 16-0210-1701 Pgs. 36-51**	Approved 1-11-18	**Pending 16-0210-1701 Pgs. 36-51**	Approved 1-16-18
0212-1701 Board/Joint	Procedures and Testing to be Performed on Newborn Infants	Jacqueline Watson 208-334-5963	**Pending 16-0212-1701 Pgs. 52-59**	Approved 1-11-18	**Pending 16-0212-1701 Pgs. 52-59**	Approved 1-22-18
0301-1701 Director (companion to 0310-1706 0318-1701 0503-1701	Eligibility for Health Care Assistance for Families and Children	Camille Schiller 208-334-5969	**Pending 16-0301-1701 Pgs. 60-62**	Approved 1-16-18	**Pending 16-0301-1701 Pgs. 60-62**	Approved 1-31-18

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0737-1701)						
0301-1702 Director	Eligibility for Health Care Assistance for Families and Children	Camille Schiller 208-334-5969	**Pending 16-0301-1702 Pgs. 63-67**	Approved 1-17-18	**Pending 16-0301-1702 Pgs. 63-67**	Approved 1-31-18
0305-1701 Director	Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)	Camille Schiller 208-334-5969	**Pending 16-0305-1701 Pgs. 68-73**	Approved 1-17-18	**Pending 16-0305-1701 Pgs. 68-73**	Approved 2-01-18
0308-1701 Director **To be REJECTED**	Temporary Assistance for Families in Idaho (TAFI)	Ericka Rupp 208-334-5641	**Pending 16-0308-1701 Pgs. 74-80**	Rejected as per request 1-17-18	**Pending 16-0308-1701 Pgs. 74-80**	Rejected as per request 2-01-18
0309-1701 Director	Medicaid Basic Plan Benefits	Art Evans 208-364-1896	**Pending 16-0309-1701 Pgs. 81-87**	Approved 1-22-18	**Pending 16-0309-1701 Pgs. 81-87**	Approved 1-25-18
0309-1702 Director (companion to 0310-1702)	Medicaid Basic Plan Benefits	Tiffany Kinzler 208-364-1989	**Pending 16-0309-1702 Pgs. 88-107**	Approved 1-17-18	**Pending 16-0309-1702 Pgs. 88-107**	Approved 2-07-18
0309-1703 Director (companion to 0310-1703)	Medicaid Basic Plan Benefits	Tiffany Kinzler 208-364-1989	**Pending 16-0309-1703 Pgs. 108-116**	Approved 1-18-18	**Pending 16-0309-1703 Pgs. 108-116**	Approved 2-07-18
0309-1704 Director (companion to 0310-1707)	Medicaid Basic Plan Benefits	Art Evans 208-364-1896	**Pending 16-0309-1704 Pgs. 117-119**	Approved 1-22-18	**Pending 16-0309-1704 Pgs. 117-119**	Approved 1-25-18
0310-1701 Director	Medicaid Enhanced Plan Benefits	Sheila Pugatch 208-287-1141	**Pending 16-0310-1701**	Approved 1-18-18	**Pending 16-0310-1701**	Approved 1-29-18

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			Pgs. 120-124		**Pgs. 120-124**	
0310-1702 Director (companion to 0309-1702)	Medicaid Enhanced Plan Benefits	Tiffany Kinzler 208-364-1989	**Pending 16-0310-1702 Pgs. 125-127**	Approved 1-17-18	**Pending 16-0310-1702 Pgs. 125-127**	Approved 2-07-18
0310-1703 Director (companion to 0309-1703)	Medicaid Enhanced Plan Benefits	Tiffany Kinzler 208-364-1989	**Pending 16-0310-1703 Pgs. 128-141**	Approved 1-18-18	**Pending 16-0310-1703 Pgs. 128-141**	Approved 2-07-18
0310-1705 Director	Medicaid Enhanced Plan Benefits	Art Evans 208-364-1896	**Pending 16-0310-1705 Pgs. 142-145**	Approved 1-22-18	**Pending 16-0310-1705 Pgs. 142-145**	Approved 1-25-18
0310-1706 Director (companion to 0301-1701 0318-1701 0503-1701 0737-1701)	Medicaid Enhanced Plan Benefits	George Gutierrez 208-364-1939	**Pending 16-0310-1706 Pgs. 146-150**	Approved 1-16-18	**Pending 16-0310-1706 Pgs. 146-150**	Approved 1-31-18
0310-1707 Director (companion to 0309-1704)	Medicaid Enhanced Plan Benefits	Art Evans 208-364-1896	**Pending 16-0310-1707 Pgs. 151-162**	Approved 1-22-18	**Pending 16-0310-1707 Pgs. 151-162**	Approved 1-25-18
0318-1701 Director (companion to 0301-1701 0310-1706 0503-1701 0737-1701)	Medicaid Cost-Sharing	George Gutierrez 208-364-1939	**Pending Fee 16-0318-1701 Pgs. 3-6**	Approved 1-16-18	**Pending Fee 16-0318-1701 Pgs. 3-6**	Approved 1-31-18

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0319-1701 Joint	Rules Governing Certified Family Homes (CFH)	Steven Millward 208-334-0706	**Pending 16-0319-1701 Pgs. 163-218**	Approved 1-12-18	**Pending 16-0319-1701 Pgs. 163-218**	Approved 2-01-18
0417-1701 Board (companion to 0417-1702)	Rules Governing Residential Habilitation Agencies	Eric Brown 208-334-0649	**Pending 16-0417-1701 Pgs. 219-221**	Approved 1-22-18	**Pending 16-0417-1701 Pgs. 219-221**	Approved 1-25-18
0417-1702 Board (companion to 0417-1701)	Rules Governing Residential Habilitation Agencies	Eric Brown 208-334-0649	**Pending 16-0417-1702 Pgs. 222-248**	Approved 1-22-18	**Pending 16-0417-1702 Pgs. 222-248**	Approved 1-25-18
0503-1701 Joint (companion to 0301-1701 0310-1706 0318-1701 0737-1701)	Rules Governing Contested Case Proceedings and Declaratory Rulings	Tamara Prisock 208-364-1971	**Pending 16-0503-1701 Pgs. 249-259**	Approved 1-16-18	**Pending 16-0503-1701 Pgs. 249-259**	Approved 1-31-18
0507-1701 Director	The Investigation and Enforcement of Fraud, Abuse, and Misconduct	Lori Stiles 208-334-0653	**Pending 16-0507-1701 Pgs. 260-264**	Approved 1-12-18	**Pending 16-0507-1701 Pgs. 260-264**	Approved 1-11-18
0601-1701 Joint	Child and Family Services	Sabrina Brown 208-334-5648	**Pending 16-0601-1701 Pgs. 265-267**	Approved 1-12-18	**Pending 16-0601-1701 Pgs. 265-267**	Approved 1-30-18
0601-1702 Joint	Child and Family Services	Carissa Decker 208-334-0692	**Pending 16-0601-1702 Pgs. 268-276**	Approved 1-12-18	**Pending 16-0601-1702 Pgs. 268-276**	Approved 1-18-18

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0612-1701 Director	Rules Governing the Idaho Child Care Program (ICCP)	Ericka Rupp 208-334-5641	**Pending 16-0612-1701 Pgs. 277-289**	Approved 1-17-18	**Pending 16-0612-1701 Pgs. 277-289**	Approved 2-01-18
0715-1701 Joint (companion to 0717-1701 0730-1701 0733-1701 0750-1701)	Behavioral Health Programs	Treena Clark 208-334-6611	**Pending 16-0715-1701 Pgs. 290-294**	Approved 1-12-18	**Pending 16-0715-1701 Pgs. 290-294**	Approved 1-29-18
0717-1701 Joint (companion to 0715-1701 0730-1701 0733-1701 0750-1701)	Substance Use Disorders Services	Treena Clark 208-334-6611	**Pending 16-0717-1701 Pgs. 295-297**	Approved 1-12-18	**Pending 16-0717-1701 Pgs. 295-297**	Approved 1-29-18
0730-1701 Director (companion to 0715-1701 0717-1701 0733-1701 0750-1701)	Behavioral Health Community Crisis Centers	Treena Clark 208-334-6611	**Pending 16-0730-1701 Pgs. 298-302**	Approved 1-12-18	**Pending 16-0730-1701 Pgs. 298-302**	Approved 1-29-18
0733-1701 Director (companion to 0715-1701 0717-1701 0730-1701	Adult Mental Health Services	Treena Clark 208-334-6611	**Pending 16-0733-1701 Pgs. 303-307**	Approved 1-12-18	**Pending 16-0733-1701 Pgs. 303-307**	Approved 1-29-18

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0737-1701 Director (companion to 0301-1701 0310-1706 0318-1701 0503-1701)	Children's Mental Health Services	Treena Clark 208-334-6611	**Pending 16-0737-1701 Pgs. 308-311**	Approved 1-16-18	**Pending 16-0737-1701 Pgs. 308-311**	Approved 1-31-18
0750-1701 Joint (companion to 0715-1701 0717-1701 0733-1701 0750-1701)	Minimum Standards for Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Units	Treena Clark 208-334-6611	**Pending 16-0750-1701 Pgs. 312-314**	Approved 1-12-18	**Pending 16-0750-1701 Pgs. 312-314**	Approved 1-29-18

DHW Legislation Tracking

2018 Legislative Session – 2nd Regular Session of the 64th Idaho Legislature

Last Updated 2/21/2018 5:14 PM

ALL 2018 LEGISLATION SUBMITTED BY DHW

Bills in red have failed Bills in blue have passed

Bill No. Topic	Description	Comments, Notes	House Action	Senate Action	Signed by Governor, Session Law	DHW Analysis Completed
H0336 **RS25614C1** **(270-05)**	*Payment for Quality Outcomes in Nursing Facilities and Intermediate Care Facilities for the Intellectually Disabled* – Ali Fernandez **MEDICAID – Amends existing law to revise provisions regarding nursing facility and intermediate care facility adjustment payments.** The intent of this legislative idea will provide Idaho's Medicaid program the authority to operate a quality program to promote improved participant outcomes and quality of services delivered. Sections 56-1501 to 56-1511, Idaho Code, Idaho Skilled Nursing Facility Assessment Act, and Sections 56-1601 to 56-1610, Idaho Code, Idaho Intermediate Care Facility Assessment Act, will both be changed to tie the Federal Upper Payment Limit (FUPL) to objective quality criteria and allow for assessment monies to pay managed care insurance companies to reimburse for these quality payments.	House Health & Welfare Floor Sponsor = Wood Harris to carry for Senate	2-9-18 Passed 68-0-2 To Senate	2-19-18 Filed for 3rd Rdg.		
H0337 **RS25615** **(270-08)**	*Regional Behavioral Health Boards* – Ross Edmunds **HEALTH – Amends existing law to define terms, revise provisions regarding the state behavioral health planning council, and revise provisions regarding regional behavioral health boards.** The intent of this legislative idea is to add definitions related to providers of peer services to support implementation of community family support and recovery support supportive services as well as update language and add prevention representation to the regional boards and state planning council membership, and establish county commissioner representation to appointing authority.	House Health & Welfare Floor Sponsor = Kingsley	2-5-18 Passed 54-16-0 To Senate	2-15-18 Filed for 3rd Reading		

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Bill No. w/link	Description	Comments/Notes	House Action	Senate Action	Governor Signed Session Law	DHW Analysis Completed
H0338 **RS25622** **(270-10)** **Replaced by H0464**	*Idaho Health Care Plan (1115 Waiver)* **HEALTH CARE – Adds to and amends existing law to authorize application for a certain waiver, provide that the Board of Directors of the Idaho Individual High-Risk Reinsurance Pool shall take certain action, provide medical assistance eligibility for certain individuals and provide that the Department of Health and Welfare will establish certain premiums.** The intent for this legislative idea is to provide and implement a 1115 Waiver for individuals with medically complex conditions for individuals under the age of 65 whose income does not exceed the limit to qualify for tax subsidies on the Health Insurance Exchange, and who are not otherwise eligible for another Medicaid program and have no access to employer sponsored coverage. The intent of this legislative ideal will allow the Dept. of Insurance agency director to implement a 1332 State Innovation Wavier to allow individual with 0-100% of the federal poverty level (PPL) to apply for advanced payment of tax credits and purchase private health insurance on Idaho's Health Insurance Marketplace (YHI).	House Health & Welfare RS Presenters, Directors: Russ Barron – Dept. of H&W Dean Cameron – Dept. of Ins. • SEE RS25947C1 for new RS	1-24-18 Info. Hearing ~~~~~~~~ ~ 1-17-18 Printed Referred to H&W			
H0341 **RS25637** **(270-09)**	*Prevention of Minors for Access to Tobacco (Permits)* – Ross Edmunds **TOBACCO – Amends existing law to establish a certain fee and to revise provisions regarding the prevention of minors' access to tobacco fund.** The intent of this legislation is to amend language related to the issuance of the annual tobacco permit from a no charge permit to a $100 fee permit and to direct collections of fees to be remitted the Prevention of Minors' Access to Tobacco Fund.	House Health & Welfare MOTION: Blanksma; to HOLD – 10-2 Motion passed. Wood & Rubel = Nay	1-30-18 Voted to HOLD in Cmte ~~~~~~~~ ~ 1-17-18 Printed Referred to H&W			

DHW Legislation Tracking
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Bill No. / Link	Description	Comments/Notes	House Action	Senate Action	Governor Signed / Session Law / DHW Analysis Completed
H0342 **RS25638** **(270-07)**	*Review, Termination of Commitments, and Discharge of Patient* – Ross Edmunds **HOSPITALIZATION OF THE MENTALLY ILL – Amends existing law to revise provisions regarding a certain notice.** The intent of this legislative idea is to amend termination or commitment and discharge of involuntary patients committed to inpatient facilities from a 30-day notice to a 10-business day notice to the committing court and prosecuting attorney under Section 66-337(b), Idaho Code. This change will allow for a timelier release from an inpatient facility that is clinically appropriate for the patient and more cost effective.	House Health & Welfare - controversy over 7 vs. 10 days notice	1-15-18 Moved to print ~~~~~~~~ ~ 1-17-18 Printed Referred to H&W ~~~~~~~~ ~ No Bill hearing was held		
H0431 **RS25639** **(270-04)**	*DHW Physicians - Non-Classified Employees* – Dave Taylor **STATE PERSONNEL SYSTEM – Amends existing law to provide that medical directors employed at state hospitals shall be nonclassified employees.** The intent of this legislative idea is to help DHW recruit and retain physicians, especially for State Hospital North and State Hospital South. To better recruit and retain qualified candidates, designate individuals employed as Physician, Medical Director, Institution at the Department of Health and Welfare mental health hospitals as non-classified to raise the pay rates offered to market-competitive levels. David Taylor, Deputy Director, Dept. of Health and Welfare	House Commerce & Human Resources Floor Sponsor = Packer	2-14-18 Passed 53-17-0 To Senate	2-15-18 Intro, 1st Rdg, Referred to Comm. & HR	

DHW Legislation Tracking

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Bill No.	Description	Comments/Notes	House Action	Senate Action	Governor Signed/ Session Law	DHW Analysis Completed
H0464 RS25947C1 Replaced H0338	*Idaho Health Care Plan (1115 Waiver)* **HEALTH CARE – Adds to and amends existing law to authorize application for a certain waiver, to provide that the board of directors of the Idaho Individual High-Risk Reinsurance Pool shall take certain action, to provide medical assistance eligibility for certain individuals and to provide that the Department of Health and Welfare will establish certain premiums and work requirements.** RS Presenters, Directors: Russ Barron – Dept. of H&W Dean Cameron – Dept. of Insurance Lori Wolff – Deputy Director of H&W House Health & Welfare	• Print hearing - Vander Woude – Believes this RS too vague. Zollinger – Questioned the list of the "complex medical cond." • Hanks thinks this is Medicaid exp. • Perry put forth MOTION – Vander Woude, Zollinger & Hanks voted NO. • 1-30-18 – WOOD suggested that information about the status of the Kentucky Medicaid lawsuit and ask that it be integrated into the presentation on Feb 7, 8:00am. • 2-7-18 -- 29 people testified • 2 presenters were OPPOSED – both from ID Freedom Foundation & Health Freedom ID (Fred Birnbaum, Jenny Peterson) • 27 presenters SUPPORT – Professionals & citizens • Original MOTION = Packer - To Floor w/ Do Pass recommendation. **Passed 7/5** • Substitute MOTION = Kingsley – To delay vote and Hold in Comm. @ discretion of Chair. Motion failed 5/7 • Perry seemed to be on fence but voted to send to the Floor. • Held until 2/27/18	2-12-18 Filed for 3rd Reading 2-13-18 Placed at bottom of 3rd Rdg calendar until 2/27/18			

	A	F	I	O	V	AB	AC	AD	AE	AH	AI
1	Total Projection										
2	FY18 2nd Quarter Review										
3		PUBLIC			BEHAVIORAL		Healthcare	Licensing		INDEPENDENT	
4		HEALTH	WELFARE	FACS	HEALTH	MEDICAID	Policy	& Cert.	Indirect	COUNCILS	
5											
6											Total
7	FY18 JFAC Action Approp:										
26	TOTAL	116,831,700	172,320,100	107,113,200	102,918,500	2,287,235,800	12,942,700	6,895,700	46,381,700	9,083,100	2,862,766,300
29											
30	Adjustments:										
31	Adjust Med Admin T&B to FN 42	-	-	-	-	(1,927,700)	-	-	-	-	-
32	Uncollective Receipt Authority / Receipts to Approp	(1,138,400)	(1,185,000)	(1,759,400)	(715,600)	(32,491,000)	-	(20,200)	(310,900)	-	(37,691,500)
33	Dedicated Fund Authority Adjustment	(4,057,000)	-	-	(30,500)	(2,525,700)	-	-	-	(136,500)	(6,749,700)
34	Federal Fund Authority Adjustment / Non-Cog Request	(3,8/3,000)	(3,435,000)	(4,005,800)	(1,746,900)	8,337,200	(985,400)	57,800	(2,074,600)	(158,300)	(7,225,500)
35	Carryover Authority - General Funds	-		-	-	-	-	-	-	-	-
36	Object Transfer - General Funds - BOOKED	-	-	-	-	-	-	-	-	-	-
37	Object Transfer - Federal Funds - BOOKED	-	-	-	-	-	-	-	-	-	-
38	Object Transfer - Receipts - BOOKED	-	-	-	-	-	-	-	-	-	-
39	Object Transfer - Dedicated Funds - BOOKED	-	-	-	-	-	-	-	-	-	-
40	Object Transfer - General Funds	-	-	-	-	-	-	-	-	-	-
41	Object Transfer - Federal Funds	-	-	-	-	-	-	-	-	-	-
42	Object Transfer - Receipts	-	-	-	-	-	-	-	-	-	-
43	Object Transfer - Dedicated Funds	-	-	-	-	-	-	-	-	-	-
44	Supplemental Request - General Funds	-	-	30,700	3,228,200	17,088,700	-	-	-	-	20,407,600
45	Supplemental Request - Federal Funds	-	-	30,700	(1,117,900)	57,134,900	-	-	-	-	56,076,200
46	Supplemental Request - Receipts	-	-	-	(460,000)	(25,000,000)	-	-	-	-	(25,460,000)
47	Supplemental Request - Dedicated Funds	-	-	-	-	9,103,700	-	-	-	-	9,103,700
48	Federal Fund Program Transfers - BOOKED	-	-	(135,700)	-	-	-	135,700	-	-	-
49	Receipt Program Transfers - BOOKED	-	-	-	-	-	-	-	-	-	-
50	General Fund Program Transfers - BOOKED	-	-	58,100	-	-	-	58,100	-	-	-
51	Program Transfer	-	-	-	-	-	-	-	-	-	-
52	Planned Federal Fund Program Transfers	-	-		-	-	-	-	-	-	
53	Planned Federal Program Transfers	120,000	(120,000)	(10,000)	-	-	-		-	10,000	-
54	Planned General Fund Program Transfers	-	-		-	-	-	138,700	(138,700)	-	-
55						-					
56	Total FY18 Est. Approp. with adjustments	107,822,700	167,630,100	101,295,900	103,085,700	2,316,156,000	12,056,300	7,265,500	43,857,500	8,798,300	2,867,968,100
57											
58											
59	Proj Expenditures w/vacancy rate	107,825,700	167,384,000	101,458,300	101,038,000	2,325,836,000	12,056,300	7,265,500	43,782,800	8,761,500	2,876,408,000
60	Variance from Appropriation	(3,000)	246,100	(162,400)	2,047,700	(9,680,000)	-	-	74,800	36,800	(7,439,900)
61											
62	General Fund Portion	(3,000)	246,100	(162,400)	2,047,700	(9,680,000)	-	-	74,800	36,800	(7,439,900)
63											
83											
105	General Fund Over <Under> by Object										
106	Personnel	(3,000)	-	-	233,800	-	-	-	51,700	36,800	384,300
107	Operating	-	(212,800)	(14,600)	287,600	(188,100)	-	-	12,700	-	(115,100)
108	Capital	-	-	1,000	-	-	-	-	500	-	1,500
109	T&B	-	458,900	(148,800)	1,491,300	(9,491,900)	-	-	-	-	(7,690,500)
110	Total:	(3,000)	246,100	(162,400)	2,047,700	(9,680,000)		-	74,900	36,800	(7,439,900)
111											
112	Diff:	-	-	-		-	-	-	-	-	-